



PERSONAL MEDICAL FORM

Name: Mr / Mrs / Miss * _____

Post applied for: (please state if part-time or full-time) _____

This form should be completed as soon as possible and returned with the application form. In the first instance it will be considered by the employing department. According to the information provided it will be decided whether the form should be referred to a medical officer, who will decide whether or not it will be necessary for you to attend a medical examination.

1. Home Address:

Postcode:

Telephone Number:

Mobile Tel:

Email:

2. Name & Address of your family doctor:

3. Are you at present receiving medical treatment? YES / NO *
(If YES please give particulars)

4. Have you ever been considered medically unfit for any previous employment, life assurance policy or HM Forces? YES / NO * (If YES please give particulars)

5. Has any abnormality ever been detected as a result of a chest x-ray? YES / NO *
(If YES please give particulars)

6. Have you ever suffered from Tuberculosis (TB)? YES / NO *
(If YES please give particulars)

7. Has anyone in your family suffered from Tuberculosis (TB)? YES / NO *

8. Have you resided outside the UK during the past five years? YES / NO *
(If YES please state countries and period(s) of residence)

9. Have you ever suffered from any of the following:
Persistent cough, chronic indigestion, pain in the chest, diabetes, breathlessness, fits, faints or dizzy
Turns, rheumatic fever, heart or kidney disease, nervous or mental illness, infectious disease (especially
Typhoid, dysentery or other infection of digestive system) YES / NO *
(If YES please give particulars)

10. Have you had any surgical operations or investigations in hospital? YES / NO*
(If YES please give particulars)

11. Have you had any other serious illness or accident not referred to above? YES / NO *
(If yes please give details)

12. Have you had any periods of sickness absence from employment longer than one month?
YES / NO * (If YES please give particulars)

13. Are you a registered disabled person? YES / NO*
(If YES please give particulars of your disability)

14. Is there any information regarding your health which is not given above, which should be taken
into account? YES / NO*

I hereby declare that all the above answers are to the best of my belief true and complete and I have not withheld any information that would help in determining my medical fitness for the post for which I am being considered. I understand that failure to disclose any material information could lead to my appointment being terminated.

I agree that, if it is considered necessary, the Medical Officer may contact my family doctor or other medical adviser about my health.

Signed: Date:

Please PRINT name:

*Please delete as necessary

When complete, return this form to:

Mrs Renée Wilkinson
Cumbria Deaf Association
Tannery Road
Harraby Green Business Park
Carlisle CA1 2SS

Or email to: renee.wilkinson@cumbriadeaf.org.uk