ENTERPRISE CARE SUPPORT LTD

DECLARATION OF HEALTH & MEDICAL FITNESS

EMPLOYEE DETAILS

Name:		Forename(s):	
Address:		Date of Birth:	
		Tel. No:	
GP Name, Address and Phone number:			

A: Do you have, or have you ever suffered from, the following:

CONDITION	NO	YES	
		Dates	Details
Typhoid Fever / Paratyphoid Fever / Enteric Fever?			
Salmonella Infection?			
Dysentery?			
TB (Tuberculosis)?			
Tropical Diseases e.g. Hookworm?			

B: Have you suffered from any of the following in the last 2 years:

CONDITION	NO	Dates	Details
Diarrhoea / Vomiting for more than 2 days?			
Chronic Bronchitis with Phlegm?			
Skin Rash / Eczema / Dermatitis / other Skin Disease?			
Recurrent Boils / Styes / Septic Fingers?			
Discharge from the Ear / Eyes / Nose?			
Fits or Blackouts?			

C: Other:

CONDITION	NO	YES	
		Dates	Details
Have you had treatment for any condition relating to the abuse or misuse of alcohol or drugs within the last 5 years?			
Have you ever had medical insurance refused, or offered subject to special conditions?			
Have you ever suffered from a back strain, or other back conditions which may affect your ability to undertake lifting and handling activities safely?			
Are you prepared to undergo a medical examination?	YES / NO		
Do you give your consent for us to contact your GP?	YES / NO		

Any other relevant information:

I confirm that the answers to these questions are true and accurate to the best of my belief and knowledge.

Signature: ____________________ ***Full Name (PRINT):*** _____________________ ***Date:*** _________________