Medical self declaration form

1. Do you suffer, or have you ever suffered from any of the following?

Symptom	Yes	No	Symptom	Yes	No
Asthma or shortness of breath (Please provide details below)			Epilepsy or blackouts (Please list any details overleaf)		
High / low blood pressure			Stomach disorders		
Any hearing disability			Liver disorders		
Diabetes (insulin dependent)			Anaemia		
Hernia			Phobia (please specify)		
Heart related problems			Drug / alcohol addiction		
Nervous disorders			Allergies (please specify)		
Back or disc related problem			Mobility problems		
Do you have any visual problems? (please provide details below)			Vibration white finger or any HAVs related condition		
Tenisynovitis (joint problems)					

2. Do you wear any spectacles or contact lenses? If yes for what reason? (eg short sight, reading)

3. Are you currently taking any medication (prescribed or over the counter)? Please give the name, mgs and how often you take it:

4. Are you registered disabled? **YES/NO**
5. Please give any details of any illness, hospitalisation, etc that may affect your ability to work in or around the railway.

6. You will be subject to screening for presence of alcohol and / or drugs either for pre-employment or on a random basis. Do you object to this? **YES/NO**
7. Name and address of personal GP

   Doctor: ……

   Address: ……

   Do you object to our approaching your GP if we require additional information about you?

8. Are you currently under any medical surveillance? (eg lead, asbestos, back problems, etc) If so, please give full details **YES/NO**

Returning to work

Is this form for a return to work, following an absence certificated by a doctor? YES / NO
Have you obtained a certificate from your doctor stating you are fit to return to work? YES / NO
Are there any restrictions to the work you are able to undertake? (please provide details) YES / NO

By signing below, you are declaring your fitness to return to work

I declare that all the information provided in this questionnaire is correct. If any of my circumstances change in regard to any of the questions asked on this form, I will immediately inform my contracts manager/supervisor/recruitment consultant and the Human Resources department at VGC.

Full name: ……

Date: …… Signature:

For office use only			
Form reviewed by:		Date:	
TSW 028 or PTS medical expiry date:			
Comments:			