Health Declaration Form for Employment

Employee Information

Full Name: ____

Date of Birth (DD/MM/YYYY): _________________________

Employee ID: ______________________________________

Department: _______________________________________

Position: ____

Health Information

Have you experienced any health issues in the past 6 months?

Yes / No

If yes, please specify: ___________________________________

Are you currently on any medication?

Yes / No

If yes, please list the medications: __________________________

Do you have any known medical conditions that may affect your work?

Yes / No

If yes, please provide details: ____________________________

Vaccination Status

Have you been vaccinated for the following?

Flu: Yes / No

COVID-19: Yes / No

Others (Please specify): ___________________________

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Declaration

I hereby declare that the information provided above is accurate to the best of my knowledge.

Signature: ____

Date: ____

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