



Strictly Confidential

PRE-EMPLOYMENT FITNESS ASSESSMENT QUESTIONNAIRE

The purpose of the questionnaire is to ensure, as far as possible, that the work you are applying for will not be detrimental to your health and that you, in turn, are not likely to be a health risk to the public or colleagues. Please give as much detail as possible about any medical conditions. If you are unsure about any aspects of the form please contact the Town Clerk.

Please return this form with your application form.

PERSONAL DETAILS	
Surname:	Forenames:
Mr/ Mrs/ Miss/ Ms. (delete as appropriate)	Date of Birth
Job for which you are applying:	
Home Address:	
Postcode:	
GP's Name:	
Address:	
Postcode:	

GENERAL HEALTH		
	If "NO" please tick	If "Yes" please give details
Have you ever claimed industrial injuries/disease compensation or benefits?		
Have you ever left, or had to modify a job due to illness or injury?		
How much time have you taken as absence from work or school in the last 2 years due to illness or injury?		
Do you consider yourself to have a disability as defined in Section One of the Disability Discrimination Act 1995?		

MEDICAL CONDITIONS

Have you had any of the following? If so, please give full details including any ongoing effect on your day to day activities. Please continue on a separate sheet if necessary.

CONDITION	If "NO" please tick	If "YES" please give details and dates
1. Fits, blackouts, epilepsy, fainting attacks, severe head injuries, frequent or severe migraine headaches.		
2. Chest problems including asthma, bronchitis, emphysema, pleurisy, persistent cough or breathlessness.		
3. Heart or circulation problems, eg., raised blood pressure, angina, stroke, chest pains.		
4. Eye disease or severe vision defects		
5. Defective colour vision		
6. Ear conditions, eg., recurring discharge or hearing loss		
7. Mental health conditions, eg., schizophrenia, depression, anxiety states, phobias, eating disorders or self-harm (including overdoses)		
8. Addiction to alcohol or any other substance		
9. Neck, back or other joint problems including arthritis, slipped disc, sciatica, recurrent backache		
10. Skin conditions, eg., eczema, psoriasis, dermatitis		
11. Gastro-intestinal conditions, including ulcers, irritable bowl syndrome, typhoid or persistent diarrhoea		
12. Diabetes, thyroid disease or any other glandular condition		
13. Liver/ kidney or bladder disease		
14. Hernia or rupture		
15. Operations (other than minor operations)		
16. Allergies to any substances		
17. Any other medical condition or disability, which you feel, may require adjustment to your work or working environment		
18. Are you taking any regular medications?		
19. What is your height?		
20. What is your weight?		
21. Do you smoke? Yes/ No. If yes, please give details of amount of cigarettes per day or oz. of tobacco per week.		
22. Average alcohol consumption per week in units (1 unit = ½ pint beer/ lager or 1 glass of wine or 1 measure of spirits)		

INFECTIOUS DISEASES		
Do you have, or have you ever had, any of the following:	If "NO" please tick	If "YES" please give details and dates
Chicken pox		
Tuberculosis (TB)		
Hepatitis B or C		
Human Immunodeficiency Virus (HIV)		

IMMUNISATIONS		
have you ever had any of the following immunisations:	If "NO" please tick	If "YES" please give details and dates
Tetanus		

DECLARATION	
1. I declare that to the best of my knowledge the above information, and that submitted in any accompanying documents, is correct. I am willing for representatives of Uckfield Town Council to make enquiries to confirm these details and for the release by other people or organisations of such information as may be necessary to Uckfield Town Council for that purpose. I understand that any false or misleading information given on this form may result in my dismissal if I am appointed.	
2. I consent to a medical interview and assessment if considered necessary.	
Signed:	Date:

FITNESS ASSESSMENT (for Office use only)	
	Tick
Fit for proposed placement?	
Fit for proposed placement subject to conditions specified below?	
Currently unfit. Review in _____ weeks recommended	
Unfit for placement proposed	
Further assessment needed. Details below:	
Signed: _____ Date: _____	
Fitness Assessment report sent YES/ NO	

