Complete Care Ltd
Medical Questionnaire
STRICTLY PRIVATE AND CONFIDENTIAL

Title of post applied for:		Job Ref:	

Before completing this form, please read the accompanying guidance notes. Please write clearly in black ink or type.

CONFIDENTIAL

1. PERSONAL DETAILS (BLOCK CAPITALS PLEASE)

Surname:		Initials:	
Address: <Town>		<Post Code>	
Telephone:			

Date of Birth:	Covid 19 vaccine received: Yes/ No

2. GENERAL PRACTITIONER'S DETAILS

Name:		Telephone Number:	
Address: Town		Post Code	

3. EQUALITY ACT 2010

Do you have a disability which may affect your ability to undertake the role of **Care Assistant** or which requires special arrangements?	☐ Yes ☐ No
The Equality Act 2010 defines a person with a disability as "A physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities."	
If yes, what facilities/adjustments/equipment might enable you to perform the role?	

4. PAST MEDICAL HISTORY

Do you have any medical conditions? If yes, please provide details below.	☐ Yes ☐ No
If yes to the above question, do any of these affect your ability to work?	☐ Yes ☐ No

Please list any prescribed medications you currently take and whether or not they may make you drowsy.

Is your eyesight ok (with glasses or contact lenses if needed) for all normal work purposes? If NO, please give details.	☐ Yes ☐ No
Is your hearing in each ear ok (with a hearing aid if needed) for all normal work purposes? If NO, please give details.	☐ Yes ☐ No
Have you suffered, or do you currently suffer, from any form of Repetitive Strain Injury (RSI)? If YES, please give details.	☐ Yes ☐ No
Have you ever left a job or had to be medically retired due to ill health? If YES, please provide details.	☐ Yes ☐ No

Do you currently smoke or vape?	☐ Yes ☐ No

5. SICKNESS ABSENCE

Please list how many days you have been absent from work, school, college etc in the last three years due to sickness. For each absence please also indicate the dates and the reason.

Number of days absence	Dates of absence (dd/mm/yy)	Reason (please state if related to a disability)

6. DECLARATION

I declare that the information given in this questionnaire is true and complete. I understand that any misleading information or any omissions will be sufficient grounds for termination of my employment.

I will notify you immediately if any of my answers change on my completed questionnaire.

I **DO/DO NOT** give permission to my General Practitioner to disclose relevant information to the <<e.g. Occupational Health Department>> in accordance with the Access to Medical Records Act 1988.

I **DO/DO NOT** wish to see my General Practitioner's comments before the questionnaire is returned to the <<e.g. Occupational Health Department or HR Manager>>.

I do/do not want to know if I am at risk of early ill-health retirement.

Name:		Signature of applicant:		Date:	

The information provided by you on this form as an applicant will be stored either on paper records or a computer system in accordance with the Data Protection Act 1998 and will be processed solely in connection with the recruitment process.