

Personal Information			
Contact Details			
First Name(s):		Last Name:	
Address:			
Telephone:	Date of Birth:	Age:	Sex: <input type="checkbox"/> Male / <input type="checkbox"/> Female
Position Applying For:			
Treating / Family Doctor:			Doctor Contact Details:
Personal Health			
Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how many per day? _____
Have you stopped smoking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when? _____
Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Average number of days per week? _____ Number of drinks per sitting? _____
Do you exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, what type? _____ Average number of days per week? _____ Length of time each session? _____
Have you any illness or disability at present?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Specify: _____
Have you been involved in a Motor Vehicle Accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
Are you taking medicines, mixtures or tablets at present?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please specify:			
Have you ever had any allergy from, or reacted to any antibiotic, medicines, drugs, insect bites, food or anything else?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please give details:			

Are you receiving treatment for any medical conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please give details:		

<b>Personal Health History: Tick Yes or No to the following questions.</b>		
Do you have any physical disability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there any defect in the sight of either eye?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you colour blind?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you any defect in hearing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you affected by vertigo (fear of heights)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you able to work while located at a height?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you suffer from claustrophobia (fear of confined spaces)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any back/neck trouble of any kind?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any heart trouble or angina?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any severe injury or operation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had any bone fractures or dislocations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had any ankle/knee trouble of any kind?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a rupture (hernia)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had wrist/elbow trouble of any kind?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had any nervous trouble, epilepsy or fainting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had any fits, seizures or blackouts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you suffered from depression or anxiety?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had skin trouble (dermatitis)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had repetitive strain injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had stomach ulcers, gall or kidney disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had whiplash from an accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there any family history of disease like diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you a tendency to bleed or bruise excessively?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had Asthma, Tuberculosis or Pleurisy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had hepatitis, jaundice or liver trouble?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had Rheumatics or Arthritis of any form?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had Goitre or Thyroid troubles?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had high blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had kidney or bladder disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had cancer or tumour of any kind?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had ear discharge, antrum or sinus trouble?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had persistent or frequent headaches/migraines?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>Personal Health History Continued: Tick Yes or No to the following questions.</b>	
Have you ever had any illness or suffered any breakdown, met with any injury or wound or undergone any surgical operation not already stated above? If yes, give details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a workers' compensation claim? If yes, give details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been involved in a Motor Vehicle Accident? If yes, give details:	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Manual Handling</b>		
Have you ever been treated for an injury as a result of attempting to lift, lower, push, pull, carry or otherwise move, hold or restrain any object?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you suffer from any medical or health related condition that may affect your ability to lift, lower, push, pull, carry or otherwise move, hold or restrain any object?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you suffer from any medical or health related condition that may be affected by physical or strenuous work? (E.g. repetitive strain injuries related to manual handling, lower back pain, hernia or haemorrhoids, a heart condition, high blood pressure, a respiratory condition such as asthma etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had or do you currently have any of the following:		
Swollen or painful joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck injury <input type="checkbox"/> Yes <input type="checkbox"/> No
RSI	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back injury <input type="checkbox"/> Yes <input type="checkbox"/> No
Knee injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other joint injury <input type="checkbox"/> Yes <input type="checkbox"/> No
Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shoulder injury <input type="checkbox"/> Yes <input type="checkbox"/> No
Ankle injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: <input type="checkbox"/> Yes <input type="checkbox"/> No
If you have answered 'yes' to any of the questions in this section, please provide details (e.g. dates, what happened, nature of injury/medical condition, treatment details, length of time off work, etc.)		

Driving																				
Are you currently being treated by a doctor for any illness or injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No																		
Are you receiving any medical treatment or taking any medication? (either prescribed or otherwise)	<input type="checkbox"/> Yes	<input type="checkbox"/> No																		
Have you ever had or been told by a doctor that you had any of the following?																				
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blackouts, fainting																		
Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke																		
Chest pain, angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness, vertigo, problems with balance																		
Any condition requiring heart surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Double vision, difficulty seeing																		
Palpitations/irregular heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Colour blindness																		
Abnormal shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease																		
Head injury, spinal injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes																		
Seizures, fits, convulsions, epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck, back or limb disorders																		
Hearing loss or deafness or had an ear operation or use a hearing aid	<input type="checkbox"/> Yes	<input type="checkbox"/> No																		
Do you have difficulty hearing people on the telephone (including use of hearing aid if worn)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No																		
Have you ever had or been told by a doctor that you had a psychiatric illness, or nervous disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No																		
Have you ever had any other serious injury, illness, operation or been in hospital for any reason?	<input type="checkbox"/> Yes	<input type="checkbox"/> No																		
Have you ever had, or been told by a doctor that you had a sleep disorder, sleep apnoea or narcolepsy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No																		
Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No																		
<p>How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.</p> <p>Use the following scale to choose the most appropriate number for each situation:</p> <p>0 - would never doze off 1 - slight chance of dozing 2 - moderate chance of dozing 3 - high chance of dozing</p> <p>It is important that you put a number (0 to 3) in each of the 8 boxes below.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Situation</th> <th style="text-align: left;">Chance of dozing (0-3)</th> </tr> </thead> <tbody> <tr> <td style="text-align: right;">Sitting and reading</td> <td><input style="width: 100%;" type="text"/></td> </tr> <tr> <td style="text-align: right;">Watching TV</td> <td><input style="width: 100%;" type="text"/></td> </tr> <tr> <td style="text-align: right;">Sitting, inactive in a public place (e.g. a theatre or meeting)</td> <td><input style="width: 100%;" type="text"/></td> </tr> <tr> <td style="text-align: right;">As a passenger in a car for an hour without a break</td> <td><input style="width: 100%;" type="text"/></td> </tr> <tr> <td style="text-align: right;">Lying down to rest in the afternoon when circumstances permit</td> <td><input style="width: 100%;" type="text"/></td> </tr> <tr> <td style="text-align: right;">Sitting and talking to someone</td> <td><input style="width: 100%;" type="text"/></td> </tr> <tr> <td style="text-align: right;">Sitting quietly after a lunch without alcohol</td> <td><input style="width: 100%;" type="text"/></td> </tr> <tr> <td style="text-align: right;">In a car, while stopped for a few minutes in the traffic</td> <td><input style="width: 100%;" type="text"/></td> </tr> </tbody> </table>			Situation	Chance of dozing (0-3)	Sitting and reading	<input style="width: 100%;" type="text"/>	Watching TV	<input style="width: 100%;" type="text"/>	Sitting, inactive in a public place (e.g. a theatre or meeting)	<input style="width: 100%;" type="text"/>	As a passenger in a car for an hour without a break	<input style="width: 100%;" type="text"/>	Lying down to rest in the afternoon when circumstances permit	<input style="width: 100%;" type="text"/>	Sitting and talking to someone	<input style="width: 100%;" type="text"/>	Sitting quietly after a lunch without alcohol	<input style="width: 100%;" type="text"/>	In a car, while stopped for a few minutes in the traffic	<input style="width: 100%;" type="text"/>
Situation	Chance of dozing (0-3)																			
Sitting and reading	<input style="width: 100%;" type="text"/>																			
Watching TV	<input style="width: 100%;" type="text"/>																			
Sitting, inactive in a public place (e.g. a theatre or meeting)	<input style="width: 100%;" type="text"/>																			
As a passenger in a car for an hour without a break	<input style="width: 100%;" type="text"/>																			
Lying down to rest in the afternoon when circumstances permit	<input style="width: 100%;" type="text"/>																			
Sitting and talking to someone	<input style="width: 100%;" type="text"/>																			
Sitting quietly after a lunch without alcohol	<input style="width: 100%;" type="text"/>																			
In a car, while stopped for a few minutes in the traffic	<input style="width: 100%;" type="text"/>																			

<b>Chemical Exposure</b>			
Have you ever been treated for an injury, illness or side effect as the result of being exposed to chemical or toxic substances or using of PPE? (eg gloves)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you suffer from any medical or health related condition that may be affected as the result of being exposed to medications, detergents, cleaning solutions, and pesticides? (eg respiratory conditions such as asthma, dermatitis or eczema, allergic reactions, etc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is there any reason that you can't wear safety or protective equipment (ie safety boots, ear muffs or plugs, helmet or safety glasses)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had or do you suffer from:			
Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dermatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of consciousness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other skin problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you have answered 'yes' to any of the questions in this section please provide details (e.g. dates, what happened, nature of injury/medical condition, treatment details, time off work, etc.)			

<b>Diving</b>			
Have you ever had:			
Decompression illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Barotrauma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vertigo / Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent or severe ear aches, infections or problems (including middle, inner or outer ear)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever had, or is it likely that you would have difficulty with the following tasks:			
Standing for up to 30 minutes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sitting for up to 30 minutes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lifting heavy weights above 15 kg	<input type="checkbox"/> Yes <input type="checkbox"/> No	Working in hot or cold extremes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Climbing ladders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Using hand tools	<input type="checkbox"/> Yes <input type="checkbox"/> No
Operating machinery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shift work	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wearing PPE	<input type="checkbox"/> Yes <input type="checkbox"/> No	Working in confined spaces	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crouching, bending or kneeling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Repetitive movements of hands or arms	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Psychological</b>		
Have you ever received medical treatment for a stress related condition? (eg ulcers, nervous trouble, insomnia, depression, anxiety or panic attacks, nervous breakdown)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever received counselling for a stress related condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you or do you suffer from a psychological condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you have answered 'yes' to any of the questions in this section please provide details (e.g. dates, what happened, nature of condition, treatment details, time off work, etc.)		

Infectious Diseases: Have you had any of the following diseases?					
Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No
German Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Immunisations: Have you been immunised against?			
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Year:
Mantoux	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Year:
Hepatitis A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Year:
Hepatitis B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Year:
Rubella	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Year:
Other:			

Applicants Declaration		
<p>Do you have any other health concerns or medical conditions you are aware of that may affect</p> <ul style="list-style-type: none"> <li>Your ability to undertake the work, or that</li> <li>This organisation should be made aware of, so that it can fulfil its own duty of care to its employees.</li> </ul> <p>If so, please provide details (e.g. dates, what happened, nature of injury/condition, treatment details, etc.)</p>		
<p>Section 79 of the <i>Western Australian Workers' Compensation and Injury Management Act 1981</i> gives a dispute resolution body discretion to refuse to award compensation which would otherwise be payable where it is proved that the worker has, at the time of seeking or entering employment in respect of which he claims compensation for an injury, wilfully and falsely represented themselves as not having previously suffered from the injury.</p>		
<p>I, _____, hereby declare that the particulars on this form are, to the best of my knowledge, correct and true.</p> <p>I also understand and am aware that any inaccurate statement made, or information withheld, may result in the termination of my employment/contract.</p>		
<b>Print Name:</b>	<b>Signed:</b>	<b>Date:</b>
Applicant:		
Witness:		