SRF06 (I) Issue 01
SELF CERT MEDICAL (INITIAL)
January 2010

Name ....

Address ....

It is important to be accurate with the answers given to this questionnaire, although there is no need to report trivial matters (e.g. transient dizziness whilst gardening two years ago).

The completion of this form is one of the initial stages in seeking employment with the company. Should you be successful in gaining employment you will be requested to complete a simpler version of this form annually – this is in addition to any medical examination that may be required for track safety training.

NOTE – any declaration made later found to be false may result in the termination of your employment with the company

Please study this list and sign the declaration on completion. A copy of this form will be retained on your personal file.

Section A

Have you ever had/suffered from any of the following? Please tick 'Yes' or 'No' box as appropriate

Where the 'Yes' box is ticked details will need to be provided

	Illness	**Yes**	**No**	**Details**
1	Asthma or lung trouble			
2	Bronchitis			
3	Pneumonia			
4	Pleurisy			
5	Persistent cough or sputum			
6	Tuberculosis			
7	Heart disease or disorder including discomfort or pain in the chest or shortness of breath on exercise (e.g. climbing a single flight of stairs)			
8	Disorders of blood or circulation including Raynaud's disease and White Finger			
9	Gastric disorder or stomach trouble			
10	Diabetes needing insulin			
11	Blackouts, recurrent dizziness or any condition which may cause sudden collapse or incapacity			
12	Difficulty in moving rapidly over short distances on foot, including slopes, steps or rough ground			
13	Difficulty looking over either shoulder?			
14	Epilepsy			
15	Headaches or migraines			
16	Nervous or mental disorder or 'nerves'			
17	Hernia /rupture			
18	Arthritis (specify osteo or rheumatoid)			
19	High blood pressure			
20	Fear of heights or Vertigo			
21	Lumbago or Fibrositis			
22	Rheumatism or arthritis			
23	Recurrent backache			

Section A (cont'd)				
	Illness	**Yes**	**No**	**Details**
24	Sciatica			
25	Any serious infectious disease			
26	Any allergy			
27	Any skin disease, eczema or dermatitis			
28	Any eye disease or disturbance or vision			
29	Any ear disease or hearing problem. Any difficulty hearing normal conversation?			
30	Any other serious illness or disability			

Section B				
		Yes	**No**	**Details**
1	Do you wear glasses?			
2	Do you wear contact lenses?			
3	Are you colour blind?			
4	Are you prevented from lifting heavy weights?			

Section C				
		Yes	**No**	**Details**
1	Has your doctor prescribed any injections, pills, and medicines etc that make you dizzy or drowsy?			
2	Have you used drugs of abuse within the last 12 months?			
3	Have you had any alcohol related illness during the last 12 months?			
4	Have you ever undergone an operation – if so, for what and when			
5	Have you consulted a doctor in the last 3 years – if so, give details			
6	Have you ever had a chest X-ray - if so, give date and result of last X-ray			
7	Have you ever claimed a disability pension or industrial injury benefit?			
8	Have you ever been absent from work, due to illness, for more than a week at a time in the last 3 years?			
9	Are you a registered disabled person?			RDP number
10	How many days sickness have you had in the past year? 0 – 5 6 – 10 11 – 20 21+ (indicate as appropriate)			
	Additional information			

Signed .... Name (print) .... Date ....