AIRSIDE DRIVER MEDICAL APPLICATION

APPLICANT TO COMPLETE IN BLOCK CAPITALS AND BRING TO THE MEDICAL EXAMINATION

Mr Mrs Miss Date of Birth Age Gender	Surname	Forenames	orenames		Title (circle)		INITIAL		RENEWAL		
PERMANENT ADDRESS POSTAL ADDRESS (if different) Home Telephone Number Permanent Address		N							11211211112			
PERMANENT ADDRESS POSTAL ADDRESS (if different) Home Telephone Number Permanent Address								Age		Gender		
PERMANENT ADDRESS POSTAL ADDRESS (if different) Home Telephone Number Work Telephone Number								J				
PERMANENT ADDRESS POSTAL ADDRESS (if different) Home Telephone Number Work Telephone Number	Place of Birth & Country				Job Title				Location	on		
Home Telephone Number Work Telephone Number		-										
Type of Examination Tick Pre Employment Pre Emplo	PERMANENT ADDRE	SS	POSTAL AD	DRESS	(if different	:)			EMPLOYER	ADDRESS		
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Type of Examination	U T-	I I M I					\A/	L. T. I l	M			
Medications currently prescribed? Y N If YES, state drug(s) and dose: State type, amount & no. of years:	Home Telephone Number			Work Telephone Number								
Medications currently prescribed? Y N If YES, state drug(s) and dose: State type, amount & no. of years:												
Medications currently prescribed? Y N If YES, state drug(s) and dose: State type, amount & no. of years:	Type of Evamination	Tick C	ront Modications		C:	olo	<u> </u>	mokina III	cton		irele	
2 Remote Worker 3 Climber/Rigger 4 Airside Driver 5 10,000 foot Medical 5 10,000 foot Medical 6 Lighting Panel Operator 7 International Work Medical 8 Fire Service 9 Other (Please state)				bed?	Y			o vou smo	ke tobacco?		Y	N
State type, amount & no. of years:					<u> </u>					INCVCI		
Date started and why:			3(1)							of years:		
Alcohol - state average weekly intake in units: Any Treatment For: City		✓						71		•		
Alcohol - state average weekly intake in units: Alcohol use Y		Dat	e started and why:									
Alcohol - state average weekly intake in units: 1 Alcohol use Y 2 Drug use Y Y N]					
Other (Please state) 2 Drug use Y	7 International Work Medical										Circ	cle
MEDICAL HISTORY - if YES please tick and describe in remarks (add supplementary notes if space insufficient) Family History of:				kly intake in units:							Υ	N
Family History of: Do YOU have a history of CONT.: 22 Depression / Other Nervous disorder	9 Other (Please state)						2	Drug use			Υ	N
Family History of: Do YOU have a history of CONT.: 22 Depression / Other Nervous disorder	MEDICAL HISTORY IF VEC place	o tick and desari	ho in romarka (add suppl	omonton	notos if an	ago inquff	ioiont)					
1 Heart Disease		e tick and descri				ace msun		Denress	ion / Other Ne	rvous disor	der	Т
2 High Blood Pressure							•					
3 Epilepsy										, doc		+
4 Mental Illness			•		III III UIIIIC					ar limh nain		+
5 Diabetes												
Have you ever been: 7 Refused life insurance 17 Neurological condition 29 Operations or surgical procedures 18 Frequent or severe headaches 30 A positive HIV test Do YOU have a history of: 9 Eye trouble / Laser eye surgery 20 Dizziness, fainting or unconsciousness 31 Any other blood tests or disorders 9 Eye trouble / Laser eye surgery 10 Hay fever or asthma REMARKS - Declaration hereby declare that have carefully considered the statements made above and that to the best of my belief they are complete and correct and that have not withheld any relevant inform made any misleading statement. understand that if have, with intent to deceive, made any false representation may be subject to disciplinary action, with invalidation of the medical assessment and notification of the appropriate authority. Prospective Candidates for employment will be held responsible for the accuracy of the above statement. By wilfully suppressing information the Candidate will in risk of losing the appointment, and if appointed, of forfeiting claim to certain superannuation benefits. SIGNED - APPLICANT Date EXAMINER (Signature) (MEDICAL USE ONLY) PR'S STAMP (MEDICAL USE ONLY) Is the candidate fit for employment as stated in "Type of Examination"? (MEDICAL USE ONLY) Y N Are there any special modifications or requirements for this individual? (MEDICAL USE ONLY) Y N												
7 Refused life insurance												
Do YOU have a history of: 19 Migraine 20 Dizziness, fainting or unconsciousness 31 Any other blood tests or disorders 32 Any other illness or injury 33 Any other illness or injury 34 Anxiety / Stress Declaration hereby declare that have carefully considered the statements made above and that to the best of my belief they are complete and correct and that have not withheld any relevant informate any misleading statement. understand that if have, with intent to deceive, made any false representation may be subject to disciplinary action, with invalidation of the medical assessment and notification of the appropriate authority. Prospective Candidates for employment will be held responsible for the accuracy of the above statement. By wilfully suppressing information the Candidate will in risk of losing the appointment, and if appointment, and if appointment, and if appointment, and if appointment and if appointment are carefully considered the statements and in appointment and if appointment are carefully considered the statements are carefully considered the statements are complete and correct and that I have not withheld any relevant information that in have not withheld any relevant information that information the Candidate will in risk of losing the appropriate authority. Prospective Candidates for employment will be held responsible for the accuracy of the above statement. By wilfully suppressing information the Candidate will in risk of losing that appropriate authority. BLOCK LETTERS (MEDICAL USE ONLY) DR'S STAMP (MEDICAL USE ONLY) BLOCK LETTERS (MEDICAL USE ONLY) V N						·						
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