AIRSIDE DRIVER MEDICAL APPLICATION

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

Surname	Forenames	Title (circle)			INITIAL	RENEWAL
		Mr	Mrs	Miss		
		Date of Birth			Age	Gender
		DD	MM	YYYY		
Place of Birth & Country		Job Title			Location	

PERMANENT ADDRESS	POSTAL ADDRESS (if different)	EMPLOYER ADDRESS

Home Telephone Number	Work Telephone Number

Type of Examination		Tick
1	Pre Employment	
2	Remote Worker	
3	Climber/Rigger	
4	Airside Driver	✓
5	10,000 foot Medical	
6	Lighting Panel Operator	
7	International Work Medical	
8	Fire Service	
9	Other (Please state)	

Current Medications	Circle	
Medications currently prescribed?	Y	N
If YES, state drug(s) and dose: Date started and why:		

Alcohol - state average weekly intake in units:

Smoking History	Circle		
Do you smoke tobacco?	Never	Y	N
Date stopped: State type, amount & no. of years:			

Any Treatment For:	Circle	
1 Alcohol use	Y	N
2 Drug use	Y	N

MEDICAL HISTORY - if YES please tick and describe in remarks (add supplementary notes if space insufficient)

Family History of:		Do YOU have a history of CONT.:			
1 Heart Disease		11 Heart trouble or high blood pressure		22 Depression / Other Nervous disorder	
2 High Blood Pressure		12 Kidney Stone / Blood / Protein in urine		23 Malaria or tropical disease	
3 Epilepsy		13 Diabetes or Sugar in urine		24 Back pain or Siatica	
4 Mental Illness		14 Stomach / Abdominal / Bowel trouble		25 Neck/shoulder or upper limb pain	
5 Diabetes		15 Head injury / concussion		26 Skin Conditions	
Have you ever been:		16 Epilepsy or fits		27 Consultation with GP in last 12 months	
7 Refused life insurance		17 Neurological condition		28 Admission to hospital	
		18 Frequent or severe headaches		29 Operations or surgical procedures	
Do YOU have a history of:		19 Migraine		30 A positive HIV test	
9 Eye trouble / Laser eye surgery		20 Dizziness, fainting or unconsciousness		31 Any other blood tests or disorders	
10 Hay fever or asthma		21 Anxiety / Stress		32 Any other illness or injury	
				Number of days sick leave in the last 2 years?	

REMARKS -

Declaration I hereby declare that I have carefully considered the statements made above and that to the best of my belief they are complete and correct and that I have not withheld any relevant information or made any misleading statement. I understand that if I have, with intent to deceive, made any false representation I 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 incur the risk of losing the appointment, and if appointed, of forfeiting claim to certain superannuation benefits.

SIGNED - APPLICANT	Date	EXAMINER (Signature) (MEDICAL USE ONLY)			DR'S STAMP (MEDICAL USE ONLY)
		BLOCK LETTERS (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	
Please describe any requirements: (MEDICAL USE ONLY)					