

Medical Assessment

Northern
House
School



This form should be returned fully completed and signed by the applicant.

This assessment is used as part of the recruitment process to identify if any adjustments are required to enable you to undertake the role.

Section 1

Surname:	Forenames:
Title:	Date of birth:
Home address: Post code:	Post applied for:
	Place of work:
	Directorate or School:
	Hours of work:
	Proposed start date:
Mobile Tel no:	Email: (Please provide an email address if this is preferred contact method)
Home Tel no:	
Work Tel no:	

Section 2

	yes	no
Do you need any special aids/adaptations to assist you at work, whether or not you have a disability?		
Have you ever been denied or left a job for health reasons?		
Are you having, or waiting for treatment or investigations of any kind at present?		
Have you ever suffered any work related ill health?		
Do you have or have you had a medical condition affecting either your physical or mental health that could affect your ability to perform the proposed job? (you should refer to the job description and selection criteria for details of the requirements to perform the job)		
Have you had any days off work due to sickness in the last 2 years – if yes please attach a list stating the number of days and the nature of the sickness absence for each period.		

If you have answered 'yes' to any of the above questions, please document details. If adjustments are required to support you at work your manager will be informed to consider if these can be put in place. No medical details will be released to a third party without your informed consent.



Section 3

Declaration by applicant

I declare that all the information given above is true and correct to the best of my knowledge. I understand that if I knowingly withhold or give inaccurate information, this may constitute grounds for the withdrawal of the offer of employment or the termination of employment if you have already started.

I acknowledge and understand that I may be expected to attend a medical assessment with the Occupational Health Service if requested.

Name (print):

Signature:

Date:

PLEASE ENSURE YOU HAVE COMPLETED ALL SECTIONS AND THAT SECTION 3 IS SIGNED AND DATED