PRE-EMPLOYMENT ASSESSMENT INFORMATION CONSENT FORM

The pre-employment assessment is performed to determine whether the duties required by your proposed position represent a health risk to yourself, or whether in performing these duties, you would pose a safety risk to other employees. Whilst participating in this pre-employment assessment is entirely voluntary, and you are not required to participate in this process, failure to answer key questions may cause your application to not be considered by a proposed employer.

The pre-employment assessment is being undertaken as your proposed employer (also encompassing your current employer or host employer, whichever is relevant) has a duty of care not to expose you or others to a risk of injury in the workplace.

Following the assessment, an opinion will be provided to your proposed employer as to your suitability for the proposed position. It will also be necessary to advise your proposed employer as to whether any modifications or limitations to your occupation / duties need to be made in order for you to safely perform those duties. The opinion will include a consideration of whether there might be a future risk that you will sustain, or exacerbate, an illness or injury.

The questions that you will answer as part of the assessment aim to ensure that you will not be exposed to injury by the examination process, that you would be able to fulfil the inherent requirements of the position you are applying for, and that you would not pose a safety risk to yourself or others in the workplace. Therefore, should the Assessor determine that your proposed occupation represents a health risk to yourself or a safety risk to others then they will inform your proposed employer of this finding. If this risk is determined to be significant it will mean you will not be considered suitable for employment in the proposed position. If it is determined that a risk can be reduced or managed by placing limitations or restrictions upon the type and nature of the work that you would perform, then the proposed employer will be advised of the limitations or restrictions. If these proposed limitations or restrictions are considered reasonable and practical by the proposed employer then employment may be offered to you with these appropriate limitations or restrictions in place. However, all decisions about whether you will or will not be employed will be made by the proposed employer, not by Konekt.

The answers that you have provided in the questionnaire and the results of the examination will be disclosed to the following persons or entities:

- Assessment staff at Konekt;
- Medical service providers who complete the assessment or a component of the assessment at Konekt's request;
- Konekt's Nominated Medical Advisors; and
- Your proposed employer's HR /Recruitment Department.

Konekt will hold, use and disclose your personal information collected as part of the pre-employment assessment in compliance with the Australian Privacy Principles and the *Privacy Act 1988*. Should your treating doctor wish to access these records he or she may forward a written request to Konekt or Konekt's Nominated Medical Advisor, with your written and signed consent. Should you personally require a copy of these records, Konekt reserves the right to charge a reasonable fee, in accordance with the *Privacy Act 1988*, for the provision of such records.

Neither Konekt nor the Nominated Medical Advisor will be responsible for any advice regarding management of any health issues found on this assessment.

This examination is important for your own safety and the safety of others at work. If you refuse to provide required information or if you provide false information, either on the questionnaire or during the physical assessment, your proposed employer may decide that your job application is unsuccessful.

Important: *If you work in Queensland and you knowingly make a false or misleading disclosure, then you will not be entitled to compensation or to seek damages for any event that aggravates the pre-existing injury or medical condition.*

Generally, the questionnaire will take about 30 minutes to complete.

SUMMARY - Please read this carefully

If you complete the questionnaire online, each question needs to be answered in order to progress to the next question. Providing false information or omitting required information may result in you not being considered for employment, or in the future this may result in you being terminated from employment. The assessment is designed to prevent you from being placed in a position that might put you or others at risk of injury, or might cause the work to aggravate an injury you already have.

I acknowledge that:

1. I have read and understood this consent form.
2. I have had the opportunity to ask questions and these have been answered in a way I understand by a representative of Konekt.
3. I consent to Konekt and the Nominated Medical Advisor conducting an assessment of my pre-employment status, including any medical conditions that may impact upon my employment, and providing my proposed employer with this assessment, including my personal (and in particular) health information, an opinion as to my suitability for the position, advice as to job modifications or limitations required to perform the job safely, and an assessment of any possible future risks.
4. I agree I am responsible for payment of fees involved in the copying of requested medical information.
5. I agree to hold harmless the examining practitioner conducting the assessment, Konekt, the Nominated Medical Advisor and my proposed employer, should there be a failure to inform me of any matter that has any relevance to my health arising from the assessment.
6. Neither the examining practitioner conducting the assessment, Konekt, or the Nominated Medical Advisor are responsible for providing me with any medical advice, management or treatment of any issues identified in this medical assessment.
7. If I am unable to read or write, I confirm that this document has been read and explained to me by person of my own choosing.
8. I consent to the Nominated Medical Advisor communicating with my treating medical practitioner/s in order to obtain further health information as required to complete the assessment.
9. In the event that a drug screen is part of my pre-employment assessment, I give my consent to Konekt and to the testing agency acting on behalf of Konekt to complete a drug screen for Marijuana, Amphetamines, Methamphetamines, Cocaine, Benzodiazepines & Opiates, and to release the results to my proposed employer.
10. I am able to withdraw this consent at any time prior to the commencement of the assessment.
11. I understand and acknowledge that if I test non-negative on the preliminary pre-employment drug screen, I give my consent to undertake a confirmatory test with a nominated laboratory.
12. I do not take illegal drugs.

Name: _____

Signature: _____ Date: _____

Pre-Employment Medical Questionnaire

Employer:		**Position:**	
First Name:		**Surname:**	
Address:			
Suburb:		**Postcode:**	
Mobile #:		**Home/Work #**	
E-Mail:			

Date of Birth: Age: Gender: Male ☐ Female ☐

Have you ever received treatment or medical advice for any of the following?

Please answer below and provide details in the space provided. If further space is required, please attach an additional page and/or any supporting documentation.

Medical Questionnaire	√ or ✕ Yes/No	Provide Details	Date first aware of issue	Is the issue now resolved? Y/N
Have you, within the last month, or are you currently taking any **over-the-counter** medication? (Drugs, tablets, mixtures or linctus from a chemist, supermarket etc.)				
Have you in the last month or are you currently taking any medications **prescribed** by a doctor? (Excludes the contraceptive pill)				
Are you taking any other drugs that you have not already mentioned including illicit or illegal drugs?				
Do you currently smoke or have you ever smoked regularly? If so for how long and (on average) how many per day.		How long have you smoked: Average number per day:		
Do you suffer from any abnormal shortness of breath?				
Do you have a persistent or regular cough?				
Have you ever (at any time) been diagnosed with or told by a doctor that you have asthma?				
Have you ever (at any time) been diagnosed with or told by a doctor that you have any disease of the lungs (other than asthma)?				

Medical Questionnaire	√ or ✕ Yes/No	Provide Details	Date first aware of issue	Is the issue now resolved? Y/N
Do you have a history deafness/hearing loss/ear disease?				
Do you either currently suffer from or regularly suffer from earache, discharging ears, sinusitis				
Do you drink alcohol?		Average no. of standard drinks per day: On average, how many days per week do you **NOT** drink alcohol:		
Do you wear glasses or contact lenses?				
Do you have a family history (father, mother, brother, sister only) of heart conditions?				
Do you have high cholesterol?				
Do you have or are you being treated for high blood pressure (hypertension)?				
Do you have a heart (cardiac) pacemaker or implanted defibrillator?				
Do you experience palpitations (rapid or irregular heart beats causing a feeling of your heart beating in your chest)?				
Have you been diagnosed with or told by a doctor that you have angina (ischemic heart disease), or heart attack (myocardial infarction)?				
Have you been diagnosed with or told by a doctor that you have a heart murmur or other heart condition other than as above?				
In the last 12 months have you suffered from chest pains?				
Have you ever been diagnosed with or told by a doctor that you have had a stroke (cerebrovascular accident) or transient ischaemic attack?				
Do you have any problems with the circulation to your legs, e.g. pain on walking, fluid build up on the ankles?				

Medical Questionnaire	√ or ✕ Yes/No	Provide Details	Date first aware of issue	Is the issue now resolved? Y/N
Do you currently have varicose veins?				
Do you suffer from fear of heights (acrophobia)?				
Do you suffer from fear of confined spaces (claustrophobia)?				
Have you ever been advised not to do shift work, night work or any other specific work?				
Is there any reason to prevent you from flying?				
Do you currently suffer from or have you ever suffered from heat stroke, heat stress, heat intolerance or heat exertional injury.				
Have you been diagnosed with diabetes by a doctor? If so what type and detail management.				
Do you often feel tired, fatigued or sleepy during day time?				
Have you been diagnosed by a doctor with sleep disorder, sleep apnoea, or narcolepsy?				
Has anyone observed you stop breathing during sleep?				
Do you snore loudly, louder than talking or loud enough to be heard through closed doors?				
Do you have or have you ever (at any time) had any skin complaints such as dermatitis or eczema?				
Do you currently or have you suffered from cancer?				
Do you have a bleeding or clotting disorder (examples: haemophilia, blood clots)?				
Do you have or have you ever (at any time) suffered from, any severe psychiatric illness such as schizophrenia, bipolar disorder or mania?				

Medical Questionnaire	√ or ✕ Yes/No	Provide Details	Date first aware of issue	Is the issue now resolved? Y/N
Do you have or have you ever (at any time) suffered from, nervous complaints, stress, depression or anxiety?				
Have you ever (at any time) had an illness or injury that has prevented you from undertaking your normal duties for more than a week?				
Have you ever (at any time) had a surgical operation which kept you from undertaking normal duties for more than one week? (Exclude: skin excisions, appendectomy, tonsillectomy, vasectomy, haemorrhoids tubal ligation, hysterectomy, caesarean section and other gynaecological operations)				
Are there any current health issues that you expect to restrict your work ability in the job you are applying for?				
Have you had or do you currently have a hernia? (Exclude hiatus hernia)				
Do you have any allergies? (drugs, chemicals, fumes etc.)				
Have you ever had any adverse reaction to workplace chemicals or substances?				
Have you ever had adverse reaction to industrial dusts? (Asbestos, coal, silica, paint, grain, etc.)				
Have you ever had any adverse reaction to industrial gases, vapours or fumes, for example welding fumes?				
Is there any condition which prevents your wearing of safety equipment (P.P.E or personal protective equipment) e.g. steel cap boots, breathing apparatus, earplugs or ear muffs?				
Do you have or have you ever (at any time) suffered from blackouts or fainting?				
Do you have or have you ever (at any time) suffered from dizziness (vertigo)?				
Have you suffered from a head injury or concussion that has resulted in brain damage or brain injury?				

Medical Questionnaire	√ or ✕ Yes/No	Provide Details	Date first aware of issue	Is the issue now resolved? Y/N
Do you have or have you ever (at any time) suffered from epilepsy or fits?				
Have you had any amputations?				
Have you had a fracture of a bone (aside from back, neck or spinal vertebrae – we will ask you about that later) or dislocation of a joint?				
Do you have or have you ever (at any time) had a shoulder injury or shoulder tendonitis?				
Do you have or have you ever (at any time) had a knee injury to the cartilage or the ligaments?				
Do you or have you ever (at any time) suffered from arthritis, gout, rheumatism, swollen, painful or stiff joints?				
Do you or have you ever (at any time) suffered from back pain or strain, sciatica or slipped disc or fractured back vertebrae?				
Do you or have you ever (at any time) suffered from neck pain, neck strain, fractured neck vertebrae or whiplash?				
Do you have or have you ever (at any time) suffered from any problems in your elbow such as golfers or tennis elbow?				
Do you have or have you ever (at any time) had problems with the tendons in the forearm or wrist including carpal tunnel?				
Do you have or have you ever (at any time) had RSI (repetitive strain injury) tenosynovitis or overuse syndrome?				
Are you concerned about any other aspect of your health? (Kidney, liver, gallbladder etc.)				

Vaccinations

Vaccination	√ or ✕ Yes/No	Date of last vaccination (If known)
Tetanus		
Hepatitis B		

Do you have difficulties with the following activities? (Please circle)

Running 100 metres	☐ **YES / NO** ☐	Climbing a ladder	☐ **YES / NO** ☐
Walking on rough ground	☐ **YES / NO** ☐	Sitting for 2 hours	☐ **YES / NO** ☐
Kneeling / Crouching	☐ **YES / NO** ☐	Lifting or bending	☐ **YES / NO** ☐
Standing for 2 hours	☐ **YES / NO** ☐	Gripping firmly with both hands	☐ **YES / NO** ☐
Turning your head rapidly	☐ **YES / NO** ☐	Reading ordinary print	☐ **YES / NO** ☐
Concentrating	☐ **YES / NO** ☐	Repetitive movements of arms	☐ **YES / NO** ☐
Balance or coordination	☐ **YES / NO** ☐	Working in hot or cold environments	☐ **YES / NO** ☐
Please comment on any answers marked as a YES:			