EMPLOYMENT MEDICAL (CONFIDENTIAL)
Non - Operator Motorised Fleet

IMPORTANT: This page is mandatory and **must be** completed by a Linfox officer prior to attending the preferred medical provider. The medical cannot proceed without completion of this mandatory page.

SURNAME: (Please print)	----------	FIRST NAME:	----------
ADDRESS:	----------		
----------		Post Code:	----------
Telephone:	----------	Mobile:	----------
Initiating Manager:	----------	Telephone:	----------
Department / Site / Location:	----------		
What is this medical for? ***(Please tick appropriate boxes)*** ☐ Weekly New Appointment ☐ Monthly New Appointment ☐ Casual New Appointment ☐ Promotion - Weekly to Monthly ☐ Change in Status Appointment (e.g. casual to permanent)		**COST CENTRE:** (Mandatory)	----------

RETURN OF MEDICALS

All medicals to be returned to:

Recruitment Administrator
Direct Recruitment
Locked Bag 2
Essendon Fields Post Office
Victoria, 3040

PH: (03) 8340 1174
FAX: (03) 8340 1178

General Notes and Instructions:

This medical is to be used for:

- New Appointments
- Promotions from Weekly to Monthly
- Appointments where there is a change in physical requirements of the position

This form must be taken by the individual to their medical appointment.

Part A is to be completed by the applicant.

Part B and C are for the doctor to complete. Applicants should allow at least one hour for the medical examination to be completed as it will involve a number of tests including a drug and alcohol screen.

PART A: MEDICAL HISTORY
(To be completed by applicant)

NAME:..... DATE OF BIRTH: / /

ADDRESS:.....

.....

PHONE (MOBILE) NO:.....

POSITION APPLIED FOR: (Please tick one of the options)

☐ Administration/Clerical/Office Based ☐ Supervisor ☐ Management ☐ Non- -Operator Motorised Fleet

☐ Other (Please specify).....

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1. Are you being treated by any Doctor for any illness? Y☐ N☐ (If yes, give details).....
2. Are you currently taking medications or drugs including inhalers? Y☐ N☐ (If yes, give details).....
3. Are you allergic to anything? Y☐ N☐ (If yes, give details).....
4. Have you ever been excessively exposed or had problems with the following (tick if yes and provide details).

   ☐ Dust ☐ Noise ☐ Chemicals ☐ Toxic metals ☐ Skin irritants ☐ Ionising radiation ☐ Other environmental hazards

   .....

   .....
5. Have you ever had an operation or spent time in hospital? Y☐ N☐ (If yes, give details) .....
6. Have you ever broken or fractured any bones? Y☐ N☐ (If yes, give details) .....
7. Have you ever had an industrial accident or disease? Y☐ N☐ (If yes, give details).....
8. Have you ever received Workers Compensation for any reason? Y☐ N☐ (If yes, give details) .....
9. Do you suffer from any back, neck or spinal problems? Y☐ N☐ (If yes, give details).....
10. Do you suffer from or have you suffered from RSI, occupational overuse syndrome, tennis elbow or tenosynovitis? Y☐ N☐

    (If yes, give details) .....
11. Do you engage in regular exercise? Y☐ N☐ (If yes, what type) .....
12. Do you smoke? Y☐ N☐ (If yes, how many cigarettes per week).....
13. Do you drink alcohol? Y☐ N☐ (If yes, what do you drink and how many glasses per week).....
14. Have you ever taken or do you use illicit substances (drugs)? Y☐ N☐
    (If yes, when/how often and what type of drug) .....
15. When was your last tetanus injection? .....
16. Do you now or have you ever suffered from any of the following (please tick box)

Tuberculosis	Y☐	N☐	Stomach or Duodenal Ulcers....	Y☐	N☐	Migraines or frequent Headaches ..	Y☐	N☐
Rheumatic Fever.....	Y☐	N☐	Passing or Vomiting Blood	Y☐	N☐	Fits / Epilepsy	Y☐	N☐
Hepatitis/Jaundice.....	Y☐	N☐	Kidney/Bladder problems	Y☐	N☐	Head Injury or Concussion.....	Y☐	N☐
HIV.....	Y☐	N☐	Back pain, Back injury, Sciatica	Y☐	N☐	Stroke.....	Y☐	N☐
Malaria, other Tropical Diseases	Y☐	N☐	Hernia	Y☐	N☐	Mental / Nervous Disorder	Y☐	N☐
Hay Fever	Y☐	N☐	Sprains / Strains.....	Y☐	N☐	Depression	Y☐	N☐
Wheezing/Asthma/Bronchitis.....	Y☐	N☐	Arthritus	Y☐	N☐	Double Vision	Y☐	N☐
Dermatitis/Eczema/Psoriasis.....	Y☐	N☐	Diabetes.....	Y☐	N☐	Colour Blindness.....	Y☐	N☐
High Blood Pressure	Y☐	N☐	Other joint injuries or conditions	Y☐	N☐	Eye Trouble	Y☐	N☐
Palpitations / Irregular Heart Beats.....	Y☐	N☐	Earache or Discharging ears	Y☐	N☐	Loss of Hearing	Y☐	N☐
Heart Murmurs.....	Y☐	N☐	Blackouts, Fainting attacks.....	Y☐	N☐	Chronic Ear Infections / Tinnitus ...	Y☐	N☐
Heart trouble, Chest pains.....	Y☐	N☐	Dizziness, Vertigo	Y☐	N☐	Other allergies	Y☐	N☐
Foot trouble, difficulty wearing shoes .	Y☐	N☐	Stress.....	Y☐	N☐			

Further details .....

.....

Linfox Drug and Alcohol Policy

Linfox has a commitment of Health & Safety that aims to achieve the highest possible standards of safety and accident prevention. Drug and Alcohol use may impair judgement and constitute a hazard in the work place. Safety levels are compromised if any of its workers are under the influence of drugs or excessive alcohol.

As part of its program of prevention, Linfox screens for the use of substances that may have an effect on Safety, including medical screening for alcohol misuse and urine drug testing. The results of the breath and urine tests are confidential and will only be made available to the Doctor who performed your medical examination and the Human Resources Officer at Linfox.

The urine drug and breath alcohol screen may show any prescribed medication you have taken recently. To assist in determining whether any substance detected is related to medication you have recently taken please complete the following details:

During the past **four** weeks have you taken any of the following?

Panadeine Forte	Y☐	N☐	Panadeine	Y☐	N☐	Codeine	Y☐	N☐	Cough Mixture	Y☐	N☐
Sudafed	Y☐	N☐	Cold and Flu tablets	Y☐	N☐	Valium	Y☐	N☐	Ducene	Y☐	N☐
Serepax	Y☐	N☐	Murelax	Y☐	N☐	Temazapan	Y☐	N☐	Normison	Y☐	N☐
Euypnos	Y☐	N☐	Rohypnol	Y☐	N☐	Sleeping tablets	Y☐	N☐	Sedatives	Y☐	N☐

Please specify any medication you are taking: .....

.....

.....

.....

Consent:

I, ... give consent to perform an alcohol breath test and testing on my urine specimen provided here today. I understand that this sample will have testing performed on it that will determine the presence of drugs and alcohol in the urine. I understand that this includes testing for but not limited to:

1. Heroin, Codeine, Methadone, Morphine and other Opiates
2. Amphetamine or "Speed"
3. Marijuana, Cannabis etc.
4. Cocaine
5. Valium, Serepax, Mogadon, Normison, Tempazepam, Ducene and other Bensodiazepines.
6. Ethanol (Alcohol)

Authorisation:

I hereby authorise Doctor .....to submit the details of the above medical examination to my prospective employer, including the results of tests for drugs and alcohol.

Applicant's signature:..... Date: .

PART B: CLINICAL EXAMINATION / RECOMMENDATION

NAME: .....

HEIGHT: ..... cm WEIGHT: .....kg BMI .....

URINE ANALYSIS

Protein Yes / No Blood Yes / No Sugar Yes / No

1 SKIN

Eczema/Dermatitis Yes / No .....
Scars Yes / No .....
Other abnormality Yes / No .....

2 CARDIOVASCULAR SYSTEM

Blood Pressure .....
Pulse rate .....
Heart sounds normal Yes / No .....
Peripheral pulses present Yes / No .....
Varicose veins Yes / No .....

3 RESPIRATORY SYSTEM

Air entry normal Yes / No .....
Symmetrical chest expansion Yes / No .....
Breath sounds Normal / Abnormal *(if abnormal give details)*
.....
Specify if further investigation required .....
.....

4 ALIMENTARY SYSTEM

Mouth and Pharynx Normal / Abnormal *(if abnormal give details)*
.....
Detectable abnormality of:
Liver Yes / No .....
Spleen Yes / No .....
Kidney Yes / No .....
Abdomen Yes / No .....

Detectable Hernia Yes / No .....

5 CENTRAL NERVOUS SYSTEM

Tremor present Yes / No .....
Reflexes
Upper Limbs – Normal Yes / No .....
Lower Limbs – Normal Yes / No .....
Coordination – Normal Yes / No .....
Power – Normal Yes / No .....
Sensation – Normal Yes / No .....
Balance – Normal Yes / No .....

6 DRUG AND ALCOHOL TESTING

Drug and Alcohol Testing completed.

Drugs: Positive ☐ Negative ☐ (tick applicable)

Alcohol: Positive ☐ Negative ☐ (tick applicable)

Comments: .....

7 MUSCULO SKELETAL SYSTEM

Cervical Spine	**Flex**	**Ext**	**Rot**	**Palp**
Full Range	☐	☐	☐	☐
Restricted	☐	☐	☐	☐

Comments .....
.....

Thoraco Lumbar Spine	Flex	Ext	Rot	Palp
Full Range	☐	☐	☐	☐
Restricted	☐	☐	☐	☐

Comments .....
.....

Evidence of Spinal Scoliosis / Spinal Kyphosis
Yes / No.....

SLR (R) ..... (L) .....

Detectable abnormality of:
Shoulder Yes / No .....
Elbow Yes / No .....
Wrist Yes / No .....
Hand Yes / No .....
Hip Yes / No .....
Knee Yes / No .....
Ankle Yes / No .....
Feet Yes / No .....

8 VISUAL ACUITY

Unaided Distance L ..... R .....
With contact lenses/glasses L ..... R .....
Other Eye test if applicable L ..... R .....
Peripheral Vision L ..... R .....
Colour Vision Normal Yes / No

9 HEARING

Auditory Canal Normal / Abnormal .....
Tympanic Membrane Normal / Abnormal .....
Audiogram Results Normal / Abnormal .....
Hearing Loss Yes / No
Binaural Hearing Loss Percentage .....%
If Hearing Loss is present, is it within prescribed licensing limits:
☐ Yes ☐ No ☐ Not Applicable

Audiogram Attached Yes / No

Comments: .....

Relevant Clinical Findings
Note comments on any relevant findings detected in the questionnaire or examination, making reference to the requirements of the standards outlined in the AFTD publication.

PART C: CLINICAL EXAMINATION / RECOMMENDATION (To be completed by the Medical Practitioner)

MEDICAL CERTIFICATE

1. EMPLOYEE DETAILS

Family name:	
Given names:	
Date of birth:	

2. MEDICAL PRACTITIONER DECLARATION

I certify that on *(Date)* *, I examined* ..... *(Patients Name)*
in accordance with Linfox Medical Assessment Standards.

Remember: *Medical clearances should NOT be given to employees with a pre-existing injury/medical condition: which may be aggravated, accelerated or exacerbated by the inherent requirements of the position under consideration; and/or which is a life-shortening condition; and/or which may endanger the lives/health of fellow workers or the public whether directly or indirectly.*

Would the performing of this role put the individual at risk of aggravating a pre-existing condition? ***Yes*** ☐ ***No*** ☐

Is the individual fit for the following duties?

☐ Light Manual Work ☐ Heavy Manual Work
☐ Office Work / Data Entry

Will the individual be able to work in the following environments? **Noisy** Yes / No **Dusty** Yes / No

I certify that I have examined the above named and consider him/her: ☐ Fit ☐ Fit with some qualifications ☐ Unfit

Note: *If fit, but with qualifications please provide the reasons for the qualification. If unfit please provide the reasons why not.*

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The examining Doctor wishes to make it known that the purpose of his examination and the consequent opinions expressed are in the interests of occupational injury by the proper placement of employees in those positions best suited to their physical capabilities. This examination is not for the purposes of determining the success or otherwise of the person's application for employment.

A person must not, in providing information, make a statement that is false or misleading. Penalties apply.

3. MEDICAL PRACTITIONER DETAILS (please print or stamp)

Medical practitioner's name:		**Signature:**		**Date:**	
Practice address:					
Facsimile number:					
Telephone number:					
Email address:					

All Pre-Employment medicals are to be returned to:

Lorna Clark
Central Recruitment
Locked Bag 2
Essendon Fields Post Office
Victoria, 3040