# PURPOSE

**This form is to be used as part of the pre-employment process for employees being appointed to the ACT Public Service. Under section 70 of the Public Sector Management Act 1994, a medical assessment is usually required for permanent appointment to the ACT Public Service.**

Your medical examination will be conducted by **Queanbeyan GP Super Clinic** which is a partner clinic of **ASPEN CORPORATE HEALTH. Please call (02) 6297 3311 to book an appointment or book online** [**here.**](https://www.aspencorporatehealth.com.au/act-government-medical-booking-form/)

You need to contact the clinic to make an appointment at your earliest convenience. Please advise the clinic that the appointment is for a Pre-Employment Assessment. **The clinic will send you an email confirming your appointment time and location.** Please pay attention to booking confirmation email**.** If you have any concerns please email Aspen Corporate Health Team at bookings@aspencorporatehealth.com.au **If you do not attend your appointment, or do not give adequate notice of cancellation [no less than 24 hours], YOU will be responsible for payment of the cancellation fee.**

# PRIVACY

The Medical Adviser will provide this form, and a medical report on the employee, to Recruitment Services, Shared Services. The information in the form and the results of the medical examination will be used for the employment purposes set out below. This is **authorised by the above-mentioned provisions of the Public Sector Management Act and Public Sector Management Standards. A copy** of the report is retained by Aspen Corporate Health.

The requesting Agency is bound by the provisions of the Health Records (Privacy and Access) Act 1997 (ACT), which protects the rights of consumers to privacy and access in relation to confidential health information.

# BEFORE THE MEDICAL EXAMINATION

* *Carefully complete the Applicant’s Details, Declaration and Authority, Employment History, Social History and the Medical History sections of the form. Bring the full Health Assessment Form with you to the medical examination.*
* ***Cancellation Policy:*** *24hrs notice is required or a 50% fee may be payable.*
* *If you have any conditions which may require investigation or explanation, you should bring any statements from your doctor(s) about the condition(s), together with copies of any specialist reports, results of any medical tests or X-Rays with you to your examination.*
* *You should also bring with you to the medical examination your glasses or contact lenses if used, and details of any medication currently being taken.*

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| **R E C R U I T M E N T O F F I C E R D E T A I L S (All fields to be completed)** |
| **Name of Employer:** | **A.C.T. GOVERNMENT** | **Directorate Name:** |  |
| Recruitment Officer’s Email: | **()** | **Report Only** |
| **Invoice to be sent to (email address):** |  | **Invoice Only** |
| Applicant’s position details: |  |
| **A P P L I C A N T ’ S D E T A I L S (Applicant to complete page 1 and 2)** |
| Last name: |  | First name(s): |  | F | M |
| D.O.B. |  | Mobile: |  | Work phone: |  |
| Address: | **,** |
| **D E C L A R A T I O N A N D A U T H O R I T Y (to be signed in Doctor’s presence)** |
| * To the best of my knowledge the answers I give for this health assessment are correct.
 |
| * I am aware that omission or misleading statements may threaten my appointment, continued employment and other benefits.
 |
| * I believe I am physically capable of performing all the inherent requirements of the proposed job.
 |
| * I do not need any adjustments to perform all the inherent requirements of the proposed job.
 |
| * I authorise ACH to provide the employer with relevant medical information required for employment purposes as per my signed Authority to release paperwork.
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| * I authorise ASPEN CORPORATE HEALTH to liaise with my doctor about my health status.
 |
| Signed: | Doctor’s Signature: |
| Date: | Office Use Only: | Report emailed o Date: comment: |

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| **E M P L O Y M E N T H I S T O R Y (List the types of jobs you have done in the past in the columns below, start with the most recent jobs)** |
| **JOB** | **EMPLOYER** | **YEAR/S** |
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| **S O C I A L H I S T O R Y** |
| Do you smoke? | NO/YES | à | How many per day? How many years have you smoked? |
| Did you smoke in the past? | NO/YES | à | How many per day? How many years did you smoke? |
| Do you drink alcohol? | NO/YES | à | How many standard drinks per day or week? |
| Do you use any other drugs? | NO/YES | à | What types and how often? |
| Do you do any regular exercise? | NO/YES | à | What types and how often? |
| **M E D I C A L H I S T O R Y (If you have EVER had any of the following, please tick the appropriate box)** |
| c 1. Heart attack, chest pain, or other heart problems | c 19. Other brain or nerve problem |
| c 2. Blood pressure problem | c 20. Back problem |
| c 3. Circulation problems | c 21. Neck problem |
| c 4. Shortness of breath, asthma, bronchitis or other lung problems | c 22. Shoulder, elbow, wrist or hand problem |
| c 5. Work related lung problem (eg asbestosis, silicosis) | c 23. Hip, knee, ankle or foot problem |
| c 6. Stomach or bowel problem | c 24. Other muscle, joint or bone problem |
| c 7. Hepatitis, jaundice or other liver or gallbladder problem | c 25. Hernia |
| c 8. Kidney or bladder problem | c 26. Dermatitis |
| c 9. Diabetes | c 27. Other skin problem |
| c 10. Thyroid problem or other glandular problem | c 28. Chronic fatigue |
| c 11. Anaemia, bleeding problem or other blood problem | c 29. Anxiety, fear of heights, fear of enclosed spaces |
| c 12. Vision (distance/near, colour, night) or eye problem | c 30. Psychiatric or mental health problem |
| c 13. Hearing, balance or ear problem | c 31. Chronic infection (eg tuberculosis, hepatitis B/C) |
| c 14. Speech, mouth or throat problem | c 32. Cancer or tumour (if not mentioned above) |
| c 15. Nose or sinus problem | c 33. Allergies |
| c 16. Epilepsy, fits, strokes, blackouts, fainting or dizziness | c 34. Regular medication |
| c 17. Head injuries | c 35. Other illness, injury, hospitalisation (if not mentioned above) |
| c 18. Severe headaches or migraines | c 36. Pension for health reasons |

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|  | **E X A M I N A T I O N F I N D I N G S (Record abnormal findings. If normal simply tick.)** |
| **GENERAL APPEARANCE** | Height: m | Weight: kg | BMI: kg/m2 |
|  | **URINE** Urinalysis |  |
|  | Urine D & A |  |
| **EYES** |  | Uncorrected | Corrected | Uncorrected | Corrected |
| Near vision | R N: | R N: | L N: | L N: |
| Distance vision | R 6 / | R 6 / | L 6 / | L 6 / |
| Colour vision (No. of errors): | Visual Fields: |
| **CARDIOVASCULAR** | Heart Rate |  |  |  | bpm reg/irreg | B.P. 1**:** |  | mmHg | B.P. 2**:** | mmHg |
| Heart sounds |
| Murmur | Veins |
|  | **RESPIRATORY** | Breath sounds/added sounds |
|  | Peak flow | Comment: |
| **EARS** | Are hearing aids worn? |  | YES / NO |  |  |  |  |  |  |  |  |  |
| Otoscope exam | L | R |
| Comment |
| Audiogram Yes No | **Hz** | 250 | 500 | 1000 | 2000 | 3000 | 4000 | 6000 | 8000 |
| **E a r** | L |  |  |  |  |  |  |  |  |
| R |  |  |  |  |  |  |  |  |
| **MOUTH/THROAT/THYROID** |  |
| **ABDOMEN** | H/S/K |
|  |
| **SPINE**- Range of movement | Cervical |
| Thoracic |
| Lumbar |
| **UPPER LIMBS*** Range of movement
* Strength
* Reflexes
 | Shoulders |
| Elbows |
| Wrists |
| Hands / Fingers |
| **LOWER LIMBS*** Range of movement
* Strength
* Reflexes
 | Hips |
| Knees |
| Ankles |
| Feet / Toes |
| Squatting |
| **SKIN****- scars, rashes, etc** |  |
| **PSYCHOLOGICAL/BEHAVIOUR** |  |

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| **R E C O M M E N D A T I O N S (Must make comments if adjustments are needed or if unfit for the inherent requirements of the job)** |
| **c Fit for all the inherent requirements of the job with no adjustments.** |
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| **c Fit for the inherent requirements of the job with some adjustments needed.** (Please comment on the nature and duration of the adjustments needed) |
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| **c Unfit temporarily for the inherent requirements of the job.** (Please comment on when they should be re-assessed, when they will be fit, and whether the person is fit for any other work) |
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| **c Unfit permanently for the inherent requirements of the job.** (Please comment on whether the person is fit for any other work) |
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| **HISTORY** |
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| **SUMMARY (Comment on history, examination and investigation findings)** |
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| **Doctor’s Name:** | **Signature:** |
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| **Phone:**  | **Date of assessment:** |