

# SELF DECLARATION OF MEDICAL FITNESS

All Emergency Management volunteers are required to complete this form.

A. Applicant details			
Mr, Mrs, Ms (Please circle)	Surname		Given name
Address			
Mobile		Email	
B. Your Health			
1.	Has there been any change to your eyesight including aids to vision that would affect your ability to perform duties as volunteer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Do you have trouble hearing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Do you have insulin-dependent diabetes or any form of controlled diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Do you have a cardiac pacemaker implanted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Are you currently on a workers compensation claim?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you currently suffer from any of the following:			
6.	Repetitive strain injury (RSI), occupational overuse syndrome (OOS), tennis elbow, pain syndrome or tenosynovitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Back, neck or spinal problems that may affect your ability to work in a safe manner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Asthma, hayfever or other allergies which may require you to wear an EPI pen	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Epilepsy, fainting attacks or fits of any kind	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have difficulty with any of the following:			
	Crouching/bending/ kneeling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sleeping	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Lifting objects	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Standing for extended periods of time	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Walking for prolonged distances	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Repetitive movement hands/arms	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Working above shoulder height	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sitting for extended periods of time	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**I declare that:**

- all answers in this Health Declaration Form are true and correct to the best of my knowledge and belief.
- I have not failed to supply any information nor provided false information.
- if I do not complete and submit this health declaration form I will not be considered for volunteer work.
- I consent to the Break O'Day Council making all reasonable enquiries in order to verify that the information provided by me in this application is true and correct.

Signature

Name

Date

**Return form together with your volunteer registration form to Council's Work Health and Safety Coordinator.**

## Privacy Statement

As required under the Personal Information Protection Act 2004

1. Personal information will be collected from you for the purpose of dealing with your application and may be used for other purposes permitted by the Local Government Act 1993 and regulations made by or under that act.
2. Failure to provide this information may result in your application not being able to be accepted and processed.
3. Your personal information will be used for the primary purpose for which it is collected and may be disclosed to contractors and agents of the Break O' Day Council.
4. Your basic personal information may be disclosed to other public sector bodies where necessary for the efficient storage and use of the information.
5. Personal information will be managed in accordance with the *Personal Information Protection Act 2004* and may be accessed by the individual to whom it relates on request to Break O' Day Council. You may be charged a fee for this service.