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|  | PRE EMPLOYMENT HEALTH DECLARATION FORM |
| Document Reference No: 046-086-FORM |

**Introduction**

Mallee Catchment Management Authority (CMA) is committed to protecting the health, safety and well-being of all employees. In line with this objective, an employee should not be required or permitted to undertake work for which they are not physically capable.

The position for which you have applied involves the tasks, duties and responsibilities as specifically detailed in the Position Description. The following information forms part of Mallee CMA’s selection process and assists in providing a safe and healthy work environment. It also helps determine if a pre-placement health assessment is required.

**Important to Note**: The *Workplace Injury Rehabilitation and Compensation Act 2013* allows the Mallee CMA to request that you to disclose any:

* pre-existing injuries, illnesses or diseases that you have suffered, or
* existing injuries, illnesses or diseases that you continue to suffer, which could be accelerated, exacerbated, aggravated or caused to recur or deteriorate by your performing the responsibilities associated with the employment for which you applying.

Where you have a pre-existing condition, consideration will be given to reasonable modification to the environment or tasks (if at all possible or practicable) with the sole intention to protect, monitor and maintain your well-being during the course of your employment with Mallee CMA.

**Please note:** If you fail to make full disclosure, or provide false and misleading information in relation to this issue, under the *Workplace Injury and Compensation Act 2013,* you and your dependent may not be entitled to workers compensation as a result of the recurrence, aggravation, acceleration, exacerbation or deterioration of any pre-existing condition arising out of, or due to, the nature of your employment, which may constitute grounds for disciplinary action including termination of employment, if employed.

**Medical History**

Do you have a:

* Pre-existing injury or illness
* Dependency upon medication
* Previous WorkCover claim

which may affect your ability to perform the activities required for the role? Yes [ ]  No [ ]

If yes, please **specify** the nature of the injury/illness/medication/claim:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Medical History** |
| Please provide the following information |
| Asthma | Yes [ ]  | No [ ]  | Arthritis | Yes [ ]  | No [ ]  |
| Anxiety/Panic Attacks | Yes [ ]  | No [ ]  | Epilepsy | Yes [ ]  | No [ ]  |
| Heart Disease | Yes [ ]  | No [ ]  | Hepatitis/HIV/AIDS | Yes [ ]  | No [ ]  |
| Skin Complaints | Yes [ ]  | No [ ]  | Migraine/Headache | Yes [ ]  | No [ ]  |
| Diabetes | Yes [ ]  | No [ ]  | Mental Illness | Yes [ ]  | No [ ]  |
| Back Injuries | Yes [ ]  | No [ ]  | Other Skeletal Injuries | Yes [ ]  | No [ ]  |
| Sprains or Strains | Yes [ ]  | No [ ]  | Are you taking any medication | Yes [ ]  | No [ ]  |
| Allergies | Yes [ ]  | No [ ]  | Other, please specify | Yes [ ]  | No [ ]  |

If you have ticked YES to any of the above, please provide further information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Emergency Contact Name** |  | **Emergency Contact No** |  |
| *I certify that the information I have provided is true and correct to the best of my knowledge and will inform Mallee CMA should any of this information change. I also agree to inform Mallee CMA of any medical condition requiring me to take medication which may affect my work performance, e.g. medication which causes drowsiness.* |
| **Signature:** |  | **Date:** |  |

**Privacy**

Any information contained or provided in response to this application will be treated as private information and will be revealed only to those people who need to know in the interest of both your health and safety, and that of your colleagues and those directly related to performing your work duties.

**Declaration**

I hereby disclose the following pre-existing injuries and diseased suffered by me of which I am aware (or could reasonably be expected to foresee) could be affected by the nature of my employment with Mallee CMA:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If any pre-existing injury or disease is not disclosed or if you have made any false or misleading disclosures, Mallee CMA hereby advises you that any recurrence, aggravation, acceleration, exacerbation or deterioration of the pre-existing injury or disease out of, in the course of, or due to the nature of your employment with Mallee CMA does not entitle you to compensation under the***Workplace Injury Rehabilitation and Compensation Act 2013 (Vic), Section 41.***

Name: insert name

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:     /     /

**File Action:** When completed this form will be filed in the HR personnel file