FORM 1

(To be completed on first visit to station)

APPLICANT MEDICAL DECLARATION

PRIVATE & CONFIDENTIAL

Volunteering with the *<<LOCAL GOVERNMENT>>* is conditional on the applicant being fit and fully able to perform all the inherent requirements of the position of volunteer fire fighter.

When completing this pre-volunteering medical declaration, it must be in full knowledge of this position's physical requirements and duties.

The intention of this medical declaration is to provide appropriate information for assessing the applicant's medical history against the designated work tasks to determine whether their proposed volunteering in this position may aggravate a pre-existing condition, precipitate a condition in a susceptible person and to determine if workplace modifications are required.

All the details provided on this form are treated confidentially and in accordance with the *<<LOCAL GOVERNMENTS>>* privacy policy.

The information requested on this medical declaration is typically disclosed to the office bearers at the Bush Fire Brigade, and the Emergency Management and Organisational Development staff. It may also be disclosed to the local government's contacts such as the preferred medical practitioner if an assessment of the applicant's suitability for volunteering and fitness for duties is required. In the event a successful applicant submits an injury claim during the course of their volunteering, this medical declaration may also be disclosed to the local government's insurer/protection provider.

Have you had any disability, injury, illness or disease, which may impact upon your ability to safely carry out the duties required of this position?

Heart disease/stroke/high blood pressure	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Migraines	☐ Yes	☐ No
Fainting/blackouts/giddiness	☐ Yes	☐ No
Hearing loss	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Fractures/ dislocation	☐ Yes	☐ No
Overuse injuries/sprain/strain	☐ Yes	☐ No
Back injury	☐ Yes	☐ No
Vision impairment (including glasses)	☐ Yes	☐ No
Other, please note	☐ Yes	☐ No

If you have answered **YES** to ANY of the above, please provide details:

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If you answered **YES** to any of the above question, are there any services or facilities which you require or which would assist you to be able to perform the inherent requirements of the position? ☐ Yes ☐ No

If **YES**, please give details

Have you ever claimed workers' compensation for an injury that may impact upon your ability to safely carry out the duties required of this position? ☐ Yes ☐ No

If **YES**, please give details

Applicant medical declaration:

I declare that I understand;

- The physical demands associated with this position, and to the best of my knowledge I have no existing medical condition that would impact my ability to safely carry out the duties required of this position.
- That the *<<LOCAL GOVERNMENT NAME>>* reserves the right to request a medical examination by a medical practitioner, at the local government's expense, at any point either before or after my membership. This may be taken into consideration when determining my suitability to safely carry out the duties of this position. I authorise the release of any such medical information, deemed appropriate for release, by the examining medical practitioner, to the local government.
- That wilfully inaccurate or misleading representation made in relation to this medical declaration may make me ineligible to volunteering, or if volunteering, liable to terminate my position.
- My membership will be made on the basis that the information I have provided is accurate, and that any false information may lead to the local government taking disciplinary action up to and including dismissal.
- This declaration will be treated confidentially and will be retained on my personnel file, which is kept secure at all times, in accordance with the <<LOCAL GOVERNMENT'S NAME>> privacy policy.

I declare that the information I have provided is true and correct:

Applicant Name (please print):

Applicant signature: Date:

Witness Name (please print):

Witness Signature: Date:

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Reviewed by:	Date:
Medical examination recommended:	☐ Yes ☐ No

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