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| **Name of Applicant** |  |

Fill in all sections of this declaration. Do not omit any relevant information. This information will be kept strictly confidential. You may be required to produce a letter from your General Practitioner to declare your fitness for work.

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| **Have you ever had:** |
| **Chest X Ray**  | ✓  | 🗶  | **Date**  | D  | M  | YY  | **Result** |  |
| **BCG Vaccination**  | ✓  | 🗶  | **Date**  | D  | M  | YY  | **Result** |  |
| **Heaf / Mantoux Test**  | ✓  | 🗶  | **Date**  | D  | M  | YY  | **Result** |  |
| **Hepatitis B** **Immunisation** | ✓  | 🗶  | **Date**  | D  | M  | YY  | **Result** |  |
| **Rubella** **Immunisation** | ✓  | 🗶  | **Date**  | D  | M  | YY  | **Result** |  |
| **Polio Immunisation**  | ✓  | 🗶  | **Date**  | D  | M  | YY  | **Result** |  |

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| **Have you ever had a serious operation?** |
| **Operation**  |  | **Date**  | D  | M  | YY  | **Result** |  |
| **Operation**  |  | **Date**  | D  | M  | YY  | **Result** |  |
| **Operation**  |  | **Date**  | D  | M  | YY  | **Result** |  |

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| **Have you experienced any of the following medical conditions?** |
| **Back Injury**  | ✓  | 🗶  | **Black Outs**  | ✓  | 🗶 |
| **Epilepsy**  | ✓  | 🗶  | **High Blood Pressure**  | ✓  | 🗶 |
| **Chest Pains**  | ✓  | 🗶  | **Shortness of Breath**  | ✓  | 🗶 |
| **Heart Disease**  | ✓  | 🗶  | **Asthma**  | ✓  | 🗶 |
| **Bronchitis**  | ✓  | 🗶  | **Tuberculosis (or Exposure To)**  | ✓  | 🗶 |
| **Diabetes**  | ✓  | 🗶  | **Poor Eyesight**  | ✓  | 🗶 |
| **Gastro-enteritis**  | ✓  | 🗶  | **Dysentery**  | ✓  | 🗶 |
| **Typhoid**  | ✓  | 🗶  | **Hernias**  | ✓  | 🗶 |
| **Stomach Ulcers**  | ✓  | 🗶  | **Rheumatism / Arthritis**  | ✓  | 🗶 |

Matrix SCM, 249 Midsummer Boulevard, Central Milton Keynes, Buckinghamshire, MK9 1EA 0844 371 4726 | www.matrix-scm.com 

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| **Measles**  | ✓  | 🗶  | **Chickenpox**  | ✓  | 🗶 |
| **German Measles**  | ✓  | 🗶  | **Skin Allergies**  | ✓  | 🗶 |
| **General Allergies**  | ✓  | 🗶  | **Mental Health Problems**  | ✓  | 🗶 |

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| **Have you had any other illness not mentioned above?**  | ✓  | 🗶 |
| **Nature of Illness** |  |
| **Date**  | DD  | MM  | YYYY |
| **Treatment Received** |  |

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| **Have you had any sickness during the past month?**  | ✓  | 🗶 |
| **Nature of Illness** |  |
| **Date**  | DD  | MM  | YYYY |
| **Treatment Received** |  |

I am currently in good health and fit for work, including right work. I agree that the information given is true to the best of my knowledge.

Failure to disclose any relevant information could lead to a revoking of your agency registration.

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| **Signed** |  |
| **Date**  | DD  | MM  | YYYY |

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