REVEST
RECRUITMENT

Personal Data

Name:		Date of Birth	
Address:		Town / City	
Phone Number:		Email Address:	
Job Role:			

Current Medical Provider

Doctor`s Name:		Phone Number:	
Address:		Town / City:	

Do you have any of the following?	Yes	No	Do you have any of the following?	Yes	No
Weight loss / Weight gain (circle)			Palpitations or skipped beats		
Fevers			Chest pain or tightness		
Headaches			Indigestion/heartburn		
Wear lenses or glasses			Abdominal pain		
Dizziness / Vertigo			Diarrhea/constipation		
Difficulty hearing			Seasonal allergies		
Sinus problems			Kidney stones		
Sleep Apnea			Back pain		
Unable to tolerate heat or cold			Joint pain or swelling		
Shortness of breath			A history of broken bones		
Wheezing / Cough			Swelling of the legs		

Covid Vaccination Status

	Yes	No		Yes	No
Have you had a Covid Vaccination?			At least one Booster?		

Current Medical Conditions

(Those that you are currently experiencing and/or receiving treatment for (such as diabetes, high blood pressure, migraine)

Please List	Date of onset	Please List	Date of onset

Past Medical Conditions

Those that you received treatment for (such as diabetes, high blood pressure, migraine)

Please List	Date of onset	Please List	Date of onset

Surgeries/Hospitalisations

List type of surgery (such as gall bladder) or condition for which you were hospitalized (such as heart attack, pneumonia)

Please List	Date of onset	Please List	Date of onset

Current Medications (if any)

Medication	Frequency	Medication	Frequency

Occupational Assessment

Please answer the following questions regarding the job for which you have been hired:	Yes	No	Unsure
Will you be required to wear respiratory protection (e.g., N95 mask or cartridge respirator)?			
Will you be required to move heavy objects regularly (i.e., greater than 20 kg frequently?)			
Will you be required to drive a vehicle for any reason, other than to get to and from work?			
If your job involves work at a computer, have you had or are you experiencing any discomfort, pain, or numbness when working at your desk?			
Have you ever had a worker's comp claim or any work-related illness or injury? If yes, Please give details			

PLEASE READ THE FOLLOWING AND SIGN WHERE INDICATED

Declaration – I solemnly declare that every answer above is true to the best of my knowledge and belief. I understand that any false or misleading information may result in termination of employment and could affect any claim for compensation for any work-related injury / accident.

Statement authorisation – Should I require a medical for the purpose of gaining employment or due to an workplace injury. I hereby authorise the examining doctor to submit a medical report regarding the above statement, physical findings, audiogram and all other investigations to my employer or their nominated representative.

Signature of employee: _____ Date: _____