Medical Questionnaire In Confidence

Please Note: This document is required to complete the registration process

In order for Smart TM Solutions to ensure that any assignments you are offered pose no threat to the health and safety of yourself, your colleagues, or the public, or so that we can consider what reasonable adjustments may be necessary in a particular assignment, please complete the relevant parts of this questionnaire fully and accurately. It may be necessary for Smart TM Solutions to request further details of any aspect of your health for these purposes.

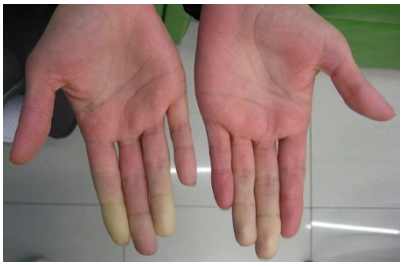
General

	Yes	No	Details
Eye trouble or defective vision not corrected by glasses			
Back trouble, other muscle or joint trouble			
Breathing issues such as asthma, hay fever or other chest trouble			
Circulatory issues such as heart trouble, high or low blood pressure, varicose veins			
Epilepsy, giddiness, fainting attacks, fits or blackouts, recurring headaches			
Do you suffer from any mental health issues			
Should we be aware of any matter affecting your ability to:			
Stand			
Sit			
Walk			
Lift			
Climb stairs			
Use your hands			

Industrial / Construction & Driving

	Yes	No	Details
Should we be aware of any matter affecting your ability to:			
Work at heights on ladders / staging			
Work in confined spaces			
Ability to drive a motor vehicle or mechanical equipment			

Vibration



Vibration can damage the blood vessels in the hands and cause the fingers to turn white.

	Yes	No	Details
Do you ever have tingling of the fingers lasting more than 20 minutes after using vibrating equipment			
Do you have tingling of the fingers at any other time			
Do you wake at night with pain, tingling or numbness to the hand or wrist			
Have your fingers gone white on cold exposure (*see picture above*)			

Noise

	Yes	No	Details
Have you noticed any loss of hearing? If yes, when did it start			
Have you ever been examined by a doctor for hearing loss			
Have you had any illness or illnesses that affected your ears or hearing			
Are you using prescribed medicine for a hearing complaint			
What kind of hearing loss are you having (*please tick options below*)			
Ringing in the ears			
Difficulty hearing on the phone			
Difficulty hearing spoken communication in one-to-one communications			
Difficulty understanding communication in the presence of surrounding noise			

Have you had any time off of work in the last 2 years because of illness or injury?

☐ Yes If yes, please provide details of your injury:_____

☐ No _____

Are you taking any prescribed medication or have any illnesses that may affect your ability to drive, operate machinery or otherwise perform your duties?

☐ Yes If yes, please provide details of your injury:_____

☐ No _____

Declaration

The medical data on this form will remain confidential to TSO Labour. The medical contents of this form will not be disclosed to anyone without your explicit or written consent.

Before signing this declaration please ensure you have answered all the questions as instructed providing further details as required. Failure to fully complete this questionnaire will result in a delay to your health clearance to complete full registration.

1. I hereby agree to inform Smart TM Solutions of any changes in my health which may affect my ability to work.
2. I acknowledge that my personal details will be stored both electronically and manually by Smart TM Solutions in accordance with the Data Protection Act 1998.
3. If I have any concerns about how this information is handled, I will contact TSO Labour.
4. I declare that the information provided by me in this entire form is true and complete to the best of my knowledge. I understand that any deliberate omission, falsification or misrepresentation may affect further sub-contracted work via TSO Labour.

Print Name:

Signed Name:

Date: