THE UNIVERSITY OF WESTERN AUSTRALIA

PRE-EMPLOYMENT MEDICAL QUESTIONNAIRE

for the position of

Laboratory Animal Technician, Animal Care Services

PERSONAL DETAILS

1. Candidate's Name: _____ _____
   Given Name Surname

   _____
   Previous Name(s)

2. Residential Address: _____

   _____

   _____

3. Contact Details: _____ _____
   After hours Phone No. Business hours Phone No.

   _____ _____
   Mobile Email

4. Have you worked in animal facilities previously? ☐ Yes ☐ No

   If yes, please give details:

   _____

   _____

   _____

POSITION DETAILS

5. Position applied for:

   _____

   _____

6. Have you received the following: ☐ Yes ☐ No

- A copy of the Position Description?
- A copy of the required physical abilities and attributes
- A copy of the Laboratory Animal Information Sheet

(Before completing this questionnaire, ensure you have a copy of the Position Description).

7. Appointment Status: ☐ Full-time ☐ Part-time

☐ Fixed Term ☐ Casual ☐ Ongoing / tenurable

PRIOR CLAIMS

8. Are you currently, or have you at any time within the last five (5) years, been in receipt of payments/damages arising from a workers' compensation claim; third party insurance claim; disability pension for sickness, incapacity, disability injury or impairment; or from any salary continuance insurance claim (or similar)?

☐ Yes ☐ No

If yes, state:

(a) name of relevant employer: _____

(b) employer's address: _____

_____

(c) type of injury/illness: _____

(d) treatment required: _____

(e) what, if any, residual disabilities exist: _____

(f) whether the claim is complete _____

N.B. Please attach additional information on any other claims /benefits.

LABORATORY ANIMAL ALLERGEN

9. Have you ever held any job involving contact with animals? If Yes, please provide details below. ☐ Yes ☐ No

_____

_____

10. Have you kept pets in the last 3 years? If Yes, please give species and dates below.

_____

_____ ☐ Yes ☐ No

11. Did you ever experience any of the symptoms when in contact with animals, their housing or tissues?

- Asthma/tight chest/wheezing YES / NO
- Bronchitis YES / NO
- Sneezing/running nose (other than colds) YES / NO
- Watery/Itching/Smarting eyes YES / NO
- Skin rashes YES / NO
- Hay Fever YES / NO
- Eczema YES / NO
- Rash (Urticaria) YES / NO

12. Has any close relative suffered from the following: ☐ Yes ☐ No

- Asthma, bronchitis, eczema, hay fever or other allergic disease?

If Yes, please give details below.

_____

_____

OTHER

13. Do you have any other condition or injury that may affect the performance of your employment? E.g. pregnancy, immuno-compromised or musculoskeletal issues? ☐ Yes ☐ No

If Yes, give details. _____

_____

14. Do you currently take any medication (prescribed or otherwise), not already disclosed that may affect your capacity to work or may have significant side effects? ☐ Yes ☐ No

If Yes, give details. _____

_____

15. In the last 12 months, have you had any ongoing health conditions which resulted in missed time from work? ☐ Yes ☐ No

If Yes, give details. _____

_____

16. In the last 12 months, have you received medical advice to have an operation or treatment for any health problems? ☐ Yes ☐ No

If Yes, give details. _____

_____

DECLARATION AND CONSENT

The following declarations are not a barrier to being considered for employment but they will assist us to take due care in assessing an appropriate placement.

I, _____ declare that:

(full name of candidate)

(i) I have read the Introduction and understand the purpose and uses that may be made of the information provided;

(ii) I have answered all questions honestly and completely;

(iii) I have not knowingly withheld any relevant information;

(iv) I have read the Position Description and I understand the inherent requirements of the position for which I have applied (or am applying);

(v) To the best of my knowledge I am able to fulfil the inherent requirements of the position;

(vi) I understand that incorrect or misleading statements or omissions may render me liable for termination of my employment or for disciplinary action and / or negate any future claim for compensable injury or illness.

If required by the University, I will attend on a medical / psychological review by a medical practitioner / psychological / occupational physician / occupational therapist engaged by the University and I irrevocably authorise that practitioner / psychologist / occupational physician or occupational therapist to provide information to the University to enable it to determine whether I am capable of fulfilling the inherent requirements of the position for which I have applied/am applying.

If my application is successful, and information disclosed in this document is required to be made known to a supervisor or manager (or other authorised person) for the purposes of ensuring the safety and health of me or others in the workplace, I grant permission for such disclosure to be made.

_____ _____

Signature of Candidate Date

ACTION: To be completed by the Manager/Supervisor of the advertised position

☐ No action required

☐ Requires further clarification by the candidate

☐ Requires medical/psychiatric/or other examination/assessment – contact the Safety, Health and Wellbeing Office 6488 2784 to arrange.

Signature: _____ Date: _____

Print Name: _____ Position: _____

SUPPLEMENTARY INFORMATION

If required to complete please use the space below: