

Pre-Employment Medical

SECTION 1 -Applicant details, declaration and authority to release medical information.

Surname:		First Name:		Date of Birth:	
Date of Assessment:	Contact Number:	Email Address:		ID No.	
				Driver Licence / Passport	
Job Title:					

My Job Tasks may include regular occupational exposure to:			
☐ Noise	☐ Dust	☐ Manual Handling >15kg	
☐ Lead	☐ UV radiation	☐ Mobile equipment operation >4 hours per shift	

APPLICANT DECLARATION AND AUTHORITY TO RELEASE MEDICAL INFORMATION

I acknowledge that the information I have provided in this application may be used for the prime purpose of ascertaining my fitness to undertake the essential inherent requirements of the proposed role without foreseeable risk to myself and others.

The information I have provided is to the best of my knowledge, true and correct.

I understand that false and/or misleading information may be sufficient cause for rejection or termination of employment.

I consent to the release of my completed Pre-employment Medical to the appropriate authorized personnel of Sibanye Stillwater.

I understand that my medical information will be stored securely and always treated with privacy and respect.

Applicant Signature:

Date:

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SECTION 2 – Health Questionnaire

Health Questionnaires assist in determining that the applicant is not at risk of aggravating a pre-existing medical condition and is able to safely conduct the specific requirements for the job. Please answer the questions contained in this questionnaire truthfully and to the best of your knowledge.

Do you have, or have you had any of the following					
		YES/NO			YES/ NO
1.	Heart disease, heart surgery, or other heart problems eg. rheumatic fever, valve disease		16.	Repetitive Strain Injury eg. tendinitis, tennis elbow, carpal tunnel syndrome	
2.	Angina, chest pain, chest tightness, palpitations, arrhythmias		17.	Pins and needles or numbness in arms, hands, legs or feet	
3.	High or low blood pressure		18.	Cancer	
4.	History of DVT, blood clots		19.	Diabetes	
5.	Stroke		20.	Hernias	
6.	Head injury		21.	Loss of appetite	
7.	Epilepsy or seizures		22.	Intestinal or bowel trouble	
8.	Blackouts, dizzy spells, fainting, loss of consciousness		23.	Weight loss or gain over the past year	
9.	Chronic headaches or migraines		24.	Indigestion / stomach ulcers	
10.	Vision problems - blurred vision, macular degeneration, cataracts, glaucoma, retinopathy		25.	Liver, kidney, or bladder problems eg. hepatitis, jaundice, kidney disease, chronic UTI's	
11.	Hearing problems eg.hearing loss, tinnitus, Meniere's Disease, chronic ear infections		26.	Tiredness, fatigue or sleeping disorder eg. insomnia, sleep apnoea	
12.	Broken bones, fractures requiring surgical repair		27.	Lung problems eg. asthma, bronchitis, pleurisy, COPD	
13.	Neck and/or back complaints or injuries eg whiplash, lumbago, sciatica, herniated disc		28.	Anxiety, depression or other mental health / psychiatric disorder	
14.	Bone or joint problems eg. osteoporosis, gout, arthritis, rheumatoid arthritis, bursitis		29.	Decreased memory and / or concentration	
15.	Muscle, tendon or ligament injuries eg weakness, sprains, strains, tears, ruptures, tendonitis		30.	Skin conditions eg. eczema, psoriasis, dermatitis,	

If you answered YES to any of the above questions, please provide further detail below:		
Number	Date and duration of condition	Current Status

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SECTION 2 – Health Questionnaire continued

Have you sustained any injuries during the course of your work?		Yes	No
If yes, please provide details			
Date	Injury Description	Ongoing or resolved	

Do you take any regular medications?		Yes	No
If yes, please provide details			
Medication Name	Strength and dosage		

Are you allergic to any medications or substances?		Yes	No
If yes, please provide details			
Name of allergen	Type of reaction		

Vaccinations and blood tests	Year	N/A
When were you immunized against Tetanus?		
When were you immunized against Hepatitis A?		
When were you immunized against Hepatitis B?		
When was your last Cholesterol test?		

Lifestyle Questionnaire	Qty / No.	N/A
How many days p/week (7 days) do you drink alcohol?		
On average, how many drinks containing alcohol would you consume in one sitting?		
On average, how many hours would you sleep p/night?		
What is the least number of hours you would sleep on a work night?		
What type of regular exercise or recreational activity do you do? eg. gym 30mins, 3 times p/week		

Respiratory Health Questionnaire			
Breathlessness			
	Yes	No	Details
Do you get short of breath when hurrying on level ground or walking up a slight hill?	☐	☐	
Do you get short of breath walking with other people of your own age on level ground?	☐	☐	
Have you at any time in the last 12 months been woken at night by an attack of shortness of breath?	☐	☐	
Wheezing and Chest Tightness			
Have you had attacks of wheezing or whistling in your chest at any time in the last 12 months?	☐	☐	
Have you ever had attacks of shortness of breath with wheezing?	☐	☐	
If Yes, was your breathing absolutely normal between attacks?	☐	☐	
Smoking			
	Yes	No	Average Qty per day
Do you or did you smoke more than one cigarette/day; a cigar/week; 2oz pipe tobacco/month?)	☐	☐	
If no – proceed to Psychological Health			
How old were you when you started smoking regularly?			
How many years did you smoke or have you been smoking ?			
If you no longer smoke, how long since			

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SECTION 2 – Health Questionnaire continued

Psychological Health Questionnaire					
Please tick the answer that is correct for you:	All of the time (5)	Most of the time (4)	Some of the time (3)	A little of the time (2)	None of the time (1)
In the past 4 weeks, about how often did you feel tired out for no good reason?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel nervous?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel hopeless?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel restless or fidgety?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel so restless you could not sit still?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel depressed?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel that everything was an effort?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel worthless?	☐	☐	☐	☐	☐

/50

Doctors comments on Psychological Health Questionnaire

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SECTION 3 – Instant Urine Drug Screen

Instant Urine Drug Screen			
Urine Drug Screen (according to AS/NZ 4308). Please note ALL non-negative results must be confirmed by GCMS.			☐ Completed
Please list all medications / substances taken in the last 7 days			
I declare that I have taken the following prescription/non-prescription medication and/or other substances in the last 7 days:			
Name:	Signature:		Date:
Urine screen device:	Batch no.:		Exp:
	Negative	Non-Negative	
Opiates	☐	☐	
THC	☐	☐	
Amphetamines	☐	☐	
Methamphetamines	☐	☐	
Benzodiazepine	☐	☐	
Adulterant Check			
Temperature			
Creatinine	mg/dl		
Specific Gravity			
Nitrite	mg/dl		
pH			

Collector Name:
Collector ID/Cert No. (if applicable):
Collector Signature:
Date:

Doctors comments on Urine drug screen

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SECTION 4 – Medical examination

General			
Height	cm	BP 1 st reading	☐ Normal ☐ Abnormal
Weight	kg	BP 2 nd reading	Pulse
Comments:			

Urinalysis			
Glucose	Protein	Blood	Keytones
☐ present ☐ absent	☐ present ☐ absent	☐ present ☐ absent	☐ present ☐ absent
Comments:			

Visual acuity					
	Uncorrected		Corrected		Ishihara: Normal / Abnormal
	Right	Left	Right	Left	Visual Fields: Normal / Abnormal
Near	N	N	N	N	Date of last optical review:
Distance					
Lenses	☐ Contacts		☐ Distance		☐ Graduated ☐ None

Cardiovascular					
	Yes	No		Yes	No
Blood pressure normal	☐	☐	Veins and other vessels normal	☐	☐
Pulse normal	☐	☐	Peripheral pulses normal	☐	☐
Heart sounds normal	☐	☐	ECG Required	☐	☐
Comments:					

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SECTION 4 - Medical examination continued

Gastrointestinal					
	Yes	No		Yes	No
Abdomen normal	☐	☐	Liver / kidney / spleen non-palpable	☐	☐
Hernia present	☐	☐	Other:	☐	☐
Comments:					

Skin					
	Yes	No		Yes	No
Normal for: skin disorders / dermatitis / infection	☐	☐	Evidence of nail biting	☐	☐
Normal for sun damage	☐	☐	Permanent scars or marks	☐	☐
Lymph nodes non-palpable	☐	☐	Normal Pallor	☐	☐
Comments:					

Nervous system					
	Yes	No		Yes	No
Balance normal	☐	☐	Tremor /Shakes/twitches absent	☐	☐
Coordination normal	☐	☐	Peripheral Sensation normal	☐	☐
Evidence of facial weakness or ptosis	☐	☐	Appropriate affect	☐	☐
Cranial nerve reflexes normal	☐	☐	Reflexes normal	☐	☐
Muscle power normal	☐	☐	Rhomberg normal	☐	☐
Comments:					

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SECTION 4 – Medical examination continued

Musculoskeletal					
Lower back	Normal	Abnormal	Joints	Normal	Abnormal
Range of movement	☐	☐	Upper limbs	☐	☐
Posture and gait	☐	☐	Lower limbs	☐	☐
Straight leg raise/squat/bend	☐	☐	Neck range of movement	☐	☐
Range of movement					
Hands	☐	☐	Knees	☐	☐
Wrists	☐	☐	Hips	☐	☐
Elbows	☐	☐	Cervical spine	☐	☐
Ankles	☐	☐	Lumbar spine	☐	☐
Shoulders	☐	☐	Dorsal spine	☐	☐
Comments:					

Audiogram									
Hz	250	500	1000	1500	2000	3000	4000	6000	8000
Right									
Left									
Audiogram result ☐ Acceptable ☐ Unacceptable					Time since last high noise exposure hours				
Auditory canals ☐ Normal ☐ Abnormal					Tympanic membranes ☐ Normal ☐ Abnormal				
Comments:									

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SECTION 4 – Medical examination continued

Respiratory					
	Yes	No		Yes	No
Breathing normal and regular in character	☐	☐	Signs of past/present respiratory disease absent?	☐	☐
Auscultation normal	☐	☐	Spirometry normal	☐	☐
Spirometry			☐ Report attached		
	Observed		Lower limit of Normal	Predicted	% Observed/Predicted
FEV1		L/min			
FVC		L/min			
FEV1/FVC		%			
Spirometry test quality			☐ Acceptable		☐ Unacceptable
Spirometry result			☐ Normal		☐ Abnormal
Note: when interpreting result refer to DRME spirometry standards and use GLI predicted values. Note: if any obstruction (ie. FEV1/FVC <70% or FEV1 < LLN, repeat spirometry after bronchodilator.					
Interpretation of results:					
Comments:					

SECTION 5 – Pathology

Pathology tests			
Blood lead test	Result:	☐ normal	☐ abnormal
Comments:			

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SECTION 6 – Fitness for Duty

Fitness for Duty			
Surname		First name	
Date of birth		Contact No.	
Employer		Site	
Position		Date of assessment	

☐ From the provided information and assessment, the applicant **is fit** to undertake the essential and inherent duties of the proposed position without foreseeable and significant risk of injury.

☐ From the provided information and assessment, the applicant **is fit** to undertake the essential and inherent duties of the proposed position with the following:

a) Restrictions:

b) Conditions:

☐ From the provided information and assessment, the applicant **is not fit** to undertake the essential and inherent duties of the proposed position without foreseeable and significant risk of injury.

Examining Doctor's Details: (please print in block letters or use stamp)			
Doctor			
Practice details			
Phone		Signature	
Email		Date	

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