**CONFIDENTIAL**

**MEDICAL REPORT**

**TO BE COMPLETED BY DOCTOR**

**Name of Applicant**: **Date of Birth**:

**Does the applicant have a condition that causes seizures, sudden loss of consciousness or sudden physical incapacity?**

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**What is the applicant’s immunisation status?**

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**Did the applicant have any previous physical or mental illness of a serious nature?**

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**Is the applicant currently receiving treatment for any physical or any mental condition? If so, give details**

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**Does the applicant have a history or substance or alcohol dependence?**

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**What is the applicant’s general state of physical health?**

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**Doctors signature**: ………………………………………………………. **Official Stamp**:

**Date** ……………………………………………………………………………

**CONFIDENTIAL**

**MEDICAL REPORT**

**TO BE COMPLETED BY APPLICANT**

**Name of applicant** …………………………………………………..**Date of birth** …………………………………..

**What is your general state of physical health?**

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**What is your general state of mental health?**

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**Are you currently receiving treatment for any physical or mental condition? If so please provide details**

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**Please detail any previous illness of a serious nature.**

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**Have you taken any addictive drugs? If so, what type and for how long?**

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**Did you receive professional treatment of the above?**

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**Applicant Signature** ……………………………………………………….........................................................

**Date**……………………………………………………………………………………………………………………………………….