Medical Fitness Confirmation

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| **Employee Name:** |  |
| **Contract:** |  |
| **Date of Transfer:** |  |
| **Job Title:** |  |

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| Knowing the role described above, do you consider yourself physically and mentally fit for the role, without the need for any adjustments to my working practices. | YES / NO |
| Do you envisage any issues with manual handling, for example using a carry chair or stretcher to safely move patients which can be strenuous? | YES / NO |
| Do you foresee any regular medical appointments that you have which may have an impact on the business or do you know of anything that may require you to have prolonged time away from the business? | YES / NO |
| Is there anything else that you would like to share regarding possible reasonable adjustments that may be required in the workplace? | YES / NO |

I understand and agree that I will be required to complete an independent Occupational Health Screening Questionnaire upon commencement of the transfer.

Signed:

Dated: