**ADDITIONAL INFORMATION QUESTIONNAIRE**

**Full Name:**

**Address:**

**Contact No:**

**We will not contact your doctor without your prior written consent. Please note that this form is placed on your Personnel File after being reviewed by the Recruiting Manager and is not shared with anyone else, unless we have your permission to do so.**

|  |  |
| --- | --- |
| 1. Are you currently taking or have been prescribed medication (excluding contraceptives)?

If YES, please give further details so that we can discuss any special requirements with you. | YES/NO |
| 1. Are you currently receiving treatment for any physical or mental condition and are you currently under the care of a Medical Professional for any reason?

If YES, please give further details so that we can discuss any special requirements with you. | YES/NO |
| 1. Do you suffer from any injury, illness, medical condition or allergy that might affect your ability to perform your duties?

If YES, please give further details so that we can discuss any special requirements with you. | YES/NO |
| 1. Do you consider yourself to have a disability?

If YES, please give further details so that we can discuss any special requirements with you. | YES/NO |

**Data Protection Notice:**

The Company requires certain information before you start employment, to ensure you will be able to perform the requirements of the job and give reliable service, and to ensure compliance with relevant Health and Safety regulations. The information is also required in order to establish whether any reasonable adjustments may need to be made to assist you in performing your duties, in accordance with the Disability provisions of the Equality Act 2010.

The information you provide will be treated in the strictest confidence, and used only for the purposes detailed above in compliance with the Data Protection Act 1998.

**I confirm that the information given in this Questionnaire is complete and accurate to the best of my knowledge.**

|  |  |
| --- | --- |
| Signature: | Date: |