It starts with equal

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Pre-employment Health Declaration

Before completing this declaration, please ensure you have read the position description and contact CARE Australia if you have any queries about the role and its requirements. Please note, all details provided on this form will be treated confidentially.

The purpose of this declaration is to ensure that you are aware of the inherent requirements of your new role (with reasonable adjustments as required) and that you have fully considered any aspects of your health that may impact on your capacity or ability to fulfil the duties of the position with CARE Australia.

I (full name): _____

Of (*current address*):_____

declare that:

- I have read an understood this form, including the above explanatory information.
- I have read the position description and understand what the role requires.
- I have completed the insurance application form and disclosed every matter that I know, or could reasonably be expected to know that may be relevant to the expatriate medical expenses insurance and understand the benefits and entitlements that are included.
- I have completed a medical and vaccination check during which I provided my medical practitioner with the position description for my role and discussed any aspect of my health that could be affected by the nature of the proposed employment.

To the best of my knowledge, the information provided in this declaration is true and correct.

Signed: _____ Date: _____

Please note, this declaration and medical check must be signed and completed prior to commencing with CARE Australia. Please ensure the completed documents are sent to Miriam.vanKeulen@care.org.au

Medical and Vaccination Check

Please print this form and provide it to your medication examiner along with a copy of your position description.

Full Name: _____

Date of Assessment: _____

Destination: _____

Medical Care Provided:
( ) Pre assignment medical assessment
( ) Other _____

Antimalarials: Yes ( ) No ( )
Medical Kit: Yes ( ) No ( )

Doctor to indicate/administer appropriate inoculation for employee deployment

Summary	Vaccines Given	Date	Follow up (Y/N)
( ) Fit for proposed placement ( ) Fit subject to special conditions ( ) Temporarily unfit ( ) Unfit for proposed assignment **Details:** Follow Up required: ( ) No ( ) Yes ( ) Local doctor ( ) Specialist **Other:**	Polio (Oral / Salk)		
	Tetanus/Diptheria (ADT)/Pertussis		
	Measles/Mumps/Rubella (MMR)		
	Chickenpox		
	Pneumoccal		
	Influenza vaccine		
	Hepatitis A (Vaqta 50/ Havrix 1440/ Avaxim)		
	Combined A/B (Twinrix)		
	Typhoid (Typhvax / Typhim Vi)		
	Meningitis: Menactra/Menveo/ Menomune		
	Japanese Encephalitis		
	Rabies (IM)		
	TB Mantoux		
	TB BCG		
	Q Fever		
	Other:		

Clinic Stamp:

Dr Name: _____

Signature: _____

Date Signed: _____