



STATEMENT OF PERSONAL HEALTH & CIRCUMSTANCES

WARNING: This document forms a part of your application for employment under the Police Act 1998 and/or the Protective Security Act 2007. Questions not correctly or fully answered, or the withholding of relevant information, may lead to prosecution for making a false statement pursuant to the provisions of Section 69 of the Police Act 1998 and/or Section 40 of the Protective Security Act 2007. A maximum penalty of \$2,500 or six months imprisonment applies.

R Tick Applicable

1. Name: _____	Date of Birth: ____ / ____ / ____
Address: _____	
Present Occupation: _____	
Past Occupation(s): _____	
Sporting Activities: _____	
2. Do you smoke tobacco?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If 'Yes', in what form and in what quantity per week? _____	

Do you take alcohol?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If 'Yes', in what form and in what quantity per week? _____	

Have you ever used illegal drugs or substances?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If 'Yes' provide details: _____	

Do you take any prescribed medications?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If 'Yes', Name and give reasons for taking them: _____	

Do you take alternative or herbal medication?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If 'Yes', Name and give reasons for taking them: _____	

Have you been immunised against Tetanus, Diphtheria, Whooping Cough, Polio, Hepatitis?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If 'Yes', state which and year of vaccination: _____	

Have you received or are you seeking compensation for any injury or illness?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If 'Yes' provide details: _____	

Have you attended or enrolled in any special education support programs during school?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If 'Yes' provide details: _____	

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3. Have you suffered from or had symptoms of any of the following. If 'Yes' indicate dates of illness, injury, operation, symptom. If space provided is insufficient please attach additional sheet with information.

(a) Asthma, pneumonia, pleurisy, persistent cough or any other infection of throat or lungs YES NO

(b) Breathing difficulties or shortness of breath YES NO

(c) Allergies, hay fever YES NO

(d) Skin disease / allergies YES NO

(e) Convulsions, fainting, concussion YES NO

(f) Learning difficulties during school YES NO

(g) Emotional disorder, eating disorder YES NO

(h) Anxiety, depression, phobia YES NO

(i) Mental illness, nervous breakdown YES NO

(j) Recurrent indigestion, stomach illness YES NO

(k) Arthritis, bone or muscular pains, or rheumatic fever YES NO

(l) Any sporting injury / fractures YES NO

(m) Disease of the bladder, the genital organs or the kidney (including renal colic stones etc.) YES NO

(n) Heart disease / condition, raised blood pressure or chest pain or raised blood cholesterol YES NO

(o) Deafness, ear discharge, dizziness, or sinus trouble YES NO

(p) Disease / condition of lung, bowel or kidney YES NO

(q) Diabetes YES NO

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(r) Cancer or tumour of any type YES NO

(s) Hernia or rupture YES NO

(t) Operations YES NO

(u) Have you ever been hospitalised? YES NO

If 'Yes' provide details:

(v) Sleeping difficulty, emotional upset or disturbing dreams / memories YES NO

(w) Self-harming episodes YES NO

Have you ever consulted a chiropractor? YES NO

If 'Yes' provide details:

Have you ever consulted a physiotherapist? YES NO

If 'Yes' provide details:

Do you wear orthotics and/or require special footwear? YES NO

If 'Yes' provide details:

Have you ever consulted a counsellor, psychiatrist, psychologist, hypnotherapist, acupuncturist, naturopath or other alternative practitioners? YES NO

If 'Yes' provide profession, name and contact details:

4. Give details of any accidents (including driving/motor vehicle accidents) or illnesses not referred to above. Include details of medical examinations, advice and/or treatments, x-rays, worker's compensation claims, motor vehicle injury claims or veteran's compensation claims.

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5. Family History: (State if deceased. Give age as at time of death).

Full Name in BLOCK Letters	Age	List any illness experienced by each and, if deceased, the cause of death
Father:
Mother:
Brother(s):
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.....
Sister(s):
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6. Has any near relative suffered from diabetes? YES NO

If 'Yes' provide details:

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7. Has any near relative suffered from epilepsy? YES NO

If 'Yes' provide details:

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8. Has any near relative suffered from any form of heart disease? YES NO

If 'Yes' provide details:

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9. Have you ever stayed or lived for an extended period (greater than 3 months) in a high Tuberculosis (TB) risk country? YES NO

If 'Yes' provide details:

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Are you aware of past contact with a TB case? YES NO

If 'Yes' provide details:

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Have you ever been treated for TB? YES NO

If 'Yes' provide details:

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Have you ever had a positive Mantoux skin test? YES NO

If 'Yes' provide details:

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Has any near relative suffered from TB? If 'Yes' provide details: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
10. Has any near relative suffered from any form of mental disease or nervous breakdown etc.? If 'Yes' provide details: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
11. Do you now, or have you at any time, worn glasses or contact lenses? If 'Yes' provide details: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you avoid, or experience difficulty when driving at night, dawn, dusk, or when visibility is low? If 'Yes' provide details: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have problems with colour discrimination or are you colour blind? If 'Yes' provide details: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
12. Do you have difficulty hearing a conversation in a noisy room? If 'Yes' provide details: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
13. Name and address of your family doctor: _____ _____ _____	
14. Have you ever been exposed to any incident or activity which you now try hard not to think about, or which drives you to avoid similar situations? If 'Yes' provide details: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
15. Have you ever witnessed the death of another person? If 'Yes' provide details: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
16. Have you ever seen a deceased person? If 'Yes' provide details: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
17. Have you ever been involved in the recovery, disposal or other handling of a deceased person? If 'Yes' provide details: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO

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18. Have you ever been directly/indirectly involved in the cause of death of another person? If 'Yes' provide details: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
19. Has any family member, friend or colleague ever been killed, unlawfully detained, assaulted or robbed? If 'Yes' provide details: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
20. Other than any previous employment with SA Police, have you worked with or for military/police agencies? If 'Yes' provide details: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
21. Have you ever lived or worked in an area subject to armed conflict, military operations, martial law, or the operation of peacekeeping forces? If 'Yes' provide details: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
22. Have you ever been involved in or witnessed the assault, robbery, unlawful detention or torture of another person? If 'Yes' provide details: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
23. Have you ever been the victim of, or witnessed a sexual assault? If 'Yes' provide details: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
24. Have you been exposed to any other event(s) or experience(s) (not covered by previous questions) which had a traumatic effect on you? If 'Yes' provide details: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO

DECLARATION

The information provided by me in this document is true and accurate to the best of my knowledge and belief.

I acknowledge that questions not correctly or fully answered, or the withholding of relevant information, may lead to prosecution for making a false statement pursuant to the provisions of Section 69 of the Police Act 1998 and/or Section 40 of the Protective Security Act 2007, and that a maximum penalty of \$2,500 or six months imprisonment applies.

(Signature of Applicant)

(Witness)

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