Presbyterian Church of Aotearoa New Zealand
Medical Assessment Form

This Form (comprising 4 pages) is to be completed and forwarded to
The Secretary, Beneficiary Fund Committee, PO Box 9049, Wellington.

The information contained in this form is collected for the purposes of assessing applicants for the National Ordained Ministry of word and sacrament in the Presbyterian Church of Aotearoa New Zealand.

The information contained in this form is also forwarded to the Committee of the Beneficiary Fund, which provides retirement and other benefits. Applicants who are accepted as ordinands or ministers are admitted to the Beneficiary Fund on confirmation of that acceptance.

Medical practitioners are requested to complete the medical history, undertake the physical examination and clearly state whether there is any recommended treatment or action.

Personal Information: *(to be completed by Applicant)*

Name: ..... Date of Birth: .....

Address: ..... Telephone: .....

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Gender: ..... Marital Status: .....

Parish: ..... Presbytery: .....

Name & address of usual doctor: .....

Current occupation: .....

Previous occupations: .....

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Declaration: *(to be completed by Applicant)*

I hereby declare that, insofar as I am aware, the information given in this form is true and complete.

I understand that the information in this medical assessment form will be made available to the Committee of the Beneficiary Fund as part of the process of assessment of me as an ordinand/minister in the Presbyterian Church of Aotearoa New Zealand.

I consent to the Presbyterian Church of Aotearoa New Zealand seeking any further medical information which they require to assess this application, and I authorise the giving of such information.

Signed by Applicant: ..... Date: .....

Witnessed: ..... Date: .....

Name of Witness (print): .....

Medical History: *(to be completed by Medical Practitioner)*

Please list any medical conditions current or occurring in the last two years: .....

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Please list any current treatments, investigations or tests in last five years: .....

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Please note any physical disabilities (including hearing/sight):.....

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Please indicate whether the candidate has ever had any significant sickness, accident or surgery requiring medical treatment and/or hospitalisation and note briefly when this occurred and what treatment/management was instituted: .....

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Please indicate smoking history:

Current smoker: YES ☐ NO ☐ State type and quantity per day: .....

Past smoker: YES ☐ NO ☐ State type and quantity per day: .....

Cessation Date: .....

Please indicate if the applicant has or has not had any of the following and note details on the following sheet.

Cardiovascular or heart disease or rheumatic fever: .....YES ☐ NO ☐

High blood pressure, angina or heart murmur: .....YES ☐ NO ☐

Disorder or disease to the circulatory system: .....YES ☐ NO ☐

Tuberculosis, asthma, bronchitis, or respiratory conditions: .....YES ☐ NO ☐

Ulcer, colitis, indigestion, gastro-intestinal or bowel conditions: .....YES ☐ NO ☐

Kidney, liver or bladder disease or disorder, hepatitis: .....YES ☐ NO ☐

Stroke, epilepsy, migraines, seizures or dizzy spells: .....YES ☐ NO ☐

Cancer, cyst, abnormal exam, smear, tumour or growth: .....YES ☐ NO ☐

Diabetes, gout, thyroid disorder or blood disorder: .....YES ☐ NO ☐

Any congenital disease, disorder or deformity: .....YES ☐ NO ☐

Any pain, injury or other condition(s) of the neck or back: .....YES ☐ NO ☐

Arthritis, tendonitis, OOS, tenosynovitis or rheumatism: .....YES ☐ NO ☐

Anxiety, stress, undue tiredness, depression or chronic fatigue: .....YES ☐ NO ☐

Excess alcohol consumption, drug abuse/dependency: .....YES ☐ NO ☐

Details of Conditions: *(to be completed by Medical Practitioner)*

Physical Examination: *(to be completed by Medical Practitioner)*

Height: .....cm Weight: .....kg Pulse: ..... Blood Pressure: .....

General observation: .....

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Cardiovascular system: .....

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Respiratory system: .....

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Gastrointestinal system: .....

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Central nervous system: .....

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Locomotor system: .....

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Mental status: .....

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Please note any instructions (including use of prescribed medication) which you consider important for the candidate to minimise any health risks and/or to enjoy optimal health?

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Signed: ..... Date: .....

Name and address of Medical Practitioner:

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S:FSD\BF