CAMBRIAN HERITAGE RAILWAYS LTD

CONFIDENTIAL WHEN COMPLETED

MEDICAL SELF ASSESSMENT FOR

CAMBRIAN HERITAGE RAILWAYS LTD DRIVER EXPERIENCE

Name: **Date of Birth:**

Address: **Phone Number:**

E-mail:

It is important to be complete and accurate with your answers to this questionnaire, and disclose anything that you feel will be important for us to know, this is to protect your own safety and that of others.

Please answer Yes, No or Don't Know

1. Do you have Diabetes needing insulin?

2. Have you ever had blackouts, fits, epilepsy, fainting attacks, recurrent dizziness, or any condition which may cause collapse or incapacity?

3. Do you get discomfort or pain in the chest, or shortness of breath when exercising – e.g., when climbing a short flight of stairs?

4. Do you have difficulty in moving rapidly over short distances, including on slopes, steps or rough ground?

5. Would you have difficulty in looking over either shoulder?

6. Are you able to meet the legal eyesight standards for driving a car (with glasses or contact lenses if normally worn)?

7. Do you have difficulty hearing a normal conversation (with hearing aid(s) if normally used)?

8. Do you have any other impairment of ability to communicate effectively?

9. Are you taking medication that could give you dizziness or drowsiness?

10. Have you used drugs of abuse (not including alcohol or tobacco) or other substance abuse within the last 12 months?

11. Have you had any illness related to alcohol in the last 12 months?

12. Do you have difficulty with or a reduction in attention or concentration?

13. Do you suffer from any mental or nervous disorder?

14. Has any Doctor advised you to refrain from any work or other activity because of a medical condition, or because of any medication you are taking?

15. Do you use hearing aids?

The information provided above is complete and correct to the best of my knowledge.

Signed **Dated**