RE-JOINING THE 2015 POLICE PENSION SCHEME

Medical questionnaire to assess the likelihood of early ill health retirement for access to ill health benefits

OFFICIAL SENSITIVE TO OPTIMA OCCUPATIONAL HEALTH
(CONFIDENTIAL WHEN COMPLETED)

MEDICAL QUESTIONNAIRE

For Official Use Only

Candidate Number

Information about the pension scheme health assessment

The questions in this medical questionnaire enable an Optima Occupational Health (OH) Physician to assess any previous or current health conditions which could lead to early ill health retirement. Advice provided by the OH Physician will be used by the MPS Pensions Department to decide whether you should be given access to ill health benefits when you apply to re-join, or are being automatically re-enrolled into, the Pension Scheme and intend to remain. In order to do this, we ask you to complete this confidential medical questionnaire.

An Optima OH Physician will review the questionnaire. If any additional medical information is required to complete the assessment, they will seek your consent to obtain the information from the relevant doctor who has been managing your care.

The information given on this form and at any subsequent consultation with the OH Physician, will be used to provide an opinion on whether you are at risk of early ill health retirement. If the OH Physician is uncertain about your risk of early ill health retirement, your case will be referred to another independent doctor called the 'Selected Medical Practitioner'.

Advice will be given to the MPS Pensions Department about your risk of early ill health retirement, who will then decide whether you can have access to ill health benefits in the 2015 Pension Scheme, by applying guidance from the Government Actuary's Department.

Please do not feel concerned if you find yourself answering 'YES' to questions. This is quite normal and does not necessarily mean that you will be found unfit to re-enter the Pension Scheme with access to ill health benefits.

Please be aware that giving false information, or withholding information, may result in your rejection or subsequent dismissal from the pension scheme or ineligibility to receive a pension or certain benefits under the scheme.

Your Details	
Surname:	Forename(s):
Title: Mr/Ms/Miss/Mrs/Other (please state)	
Date of Birth:	Male/Female (delete as appropriate)
Full postal address including postcode:	
Email:	
Mobile:	Home Telephone:
General Practitioner's Details ***(please note if we need to contact your GP for further information we will ask for your consent later to do this)***	
Name:	Telephone Number:
Full postal address including name of Health Centre/GP Practice and postcode:	

Please answer ALL the following questions:

Medical Conditions			
Do you currently have or have you ever had any of the following medical conditions? If you tick 'Yes', please give details in the space provided on Page 10 and ensure that you state the correct medical condition number.			
1	Epilepsy, fits, blackouts, fainting or unexplained loss of consciousness?	**Yes** □	**No** □
2	Head injuries leading to loss of consciousness and/or requiring hospital investigation?	**Yes** □	**No** □
3	Recurrent headache or migraine?	**Yes** □	**No** □
4	Diseases of the nervous system e.g. neuritis, stroke, multiple sclerosis?	**Yes** □	**No** □
5	Injury or surgery to your eye(s) including laser eye surgery or any other type of refractive surgery?	**Yes** □	**No** □
6	Any visual defect e.g. scotoma, blindness in one eye, night blindness, colour blindness, reduced visual field, blurred vision or detached retina?	**Yes** □	**No** □
7	Any eye disease or conditions such as glaucoma or retinitis pigmentosa?	**Yes** □	**No** □
8	Ear infection, discharge, tinnitus, a hearing defect including deafness?	**Yes** □	**No** □
9	Vertigo, dizziness, giddiness, problems with balance?	**Yes** □	**No** □

10	Chest pain, angina, heart disease, history of rheumatic fever or breathlessness?	**Yes** □	**No** □
11	Varicose veins or circulation problems?	**Yes** □	**No** □
12	Any infectious diseases (apart from childhood illnesses) including sexually transmitted disease or tropical disease?	**Yes** □	**No** □
13	Raised or low blood pressure?	**Yes** □	**No** □
14	Any blood disorder (e.g. anaemia)?	**Yes** □	**No** □
15	Asthma, bronchitis, emphysema, pleurisy, pneumonia or any other lung disease including TB or pneumothorax?	**Yes** □	**No** □
16	Recurrent nausea, dyspepsia, heartburn, indigestion or hiatus hernia?	**Yes** □	**No** □
17	Gastric, duodenal or peptic ulcer?	**Yes** □	**No** □
18	Inflammation of the bowel including Crohn's Disease, ulcerative colitis, bleeding from rectum or diarrhoea lasting more than one week?	**Yes** □	**No** □
19	Irritable bowel syndrome?	**Yes** □	**No** □
20	Jaundice or any form of hepatitis or other liver problem?	**Yes** □	**No** □

Medical Conditions (continued)			
21	Any other abdominal complaint including hernia?	**Yes** □	**No** □
22	Kidney stones?	**Yes** □	**No** □
23	Recurrent kidney or urinary tract infection e.g. cystitis and urethritis?	**Yes** □	**No** □
24	Blood in urine?	**Yes** □	**No** □
25	Any other kidney or bladder conditions?	**Yes** □	**No** □
26	Any problems with bones or joints including back, neck, knee, sciatica, any fracture or dislocation?	**Yes** □	**No** □
27	Have you ever consulted an orthopaedic surgeon, rheumatologist, chiropractor, osteopath or physiotherapist?	**Yes** □	**No** □
28	Have you been diagnosed as having arthritis, rheumatism, degenerative joint condition?	**Yes** □	**No** □
29	Psoriasis, eczema, allergic skin rash or other skin disease?	**Yes** □	**No** □
30	Any metabolic disorder including diabetes, other glandular disorder such as thyroid, pituitary and adrenal gland disease?	**Yes** □	**No** □
31	Any disorders of reproductive organs including gynaecological, testicular and breast problems?	**Yes** □	**No** □

32	Anxiety/depression, phobias, mental breakdown or stress related problems?	**Yes** □	**No** □
33	Any other mental illness?	**Yes** □	**No** □
34	Have you ever harmed yourself intentionally e.g. by cutting or taking an overdose?	**Yes** □	**No** □
35	Any eating disorder e.g. anorexia nervosa or bulimia?	**Yes** □	**No** □
36	Substance misuse (e.g. drugs, steroids)?	**Yes** □	**No** □
37	Any allergies, including hayfever?	**Yes** □	**No** □
38	Any operations or surgical procedures?	**Yes** □	**No** □
39	Any malignancies or cancers?	**Yes** □	**No** □
40	Any unexplained weight loss in the past year?	**Yes** □	**No** □
41	Are you currently attending a clinic (e.g. GP, hospital, therapist) for treatment or are you waiting for an appointment?	**Yes** □	**No** □
42	Are you currently prescribed medication including tablets, capsules, injections, inhalers and creams?	**Yes** □	**No** □

If you have ticked 'Yes' to any of the above, please give details in the space provided on page 10. Please ensure that you state the correct medical condition number.

Details of Medical Conditions

Please include dates of illness/conditions, duration, what treatment was given and by whom (e.g. hospital/GP), including length of absence from work, whether you are still undergoing treatment. If you have ever been hospitalised, please give details. Continue on separate sheet if required.

Medical Condition Number (from the conditions listed on pages 6-9)	**Details**

Alcohol Consumption		
How much alcohol do you consume over a seven day period? **Units per week (1 unit = ½ pint beer = 1 glass of wine = 1 measure of spirits)**		
Past Medical History		
Have you ever failed a medical examination (or had special conditions imposed) for any employment reasons (including police service and HM Forces) or life assurance? If YES, please provide details.	**Yes** □	**No** □
Have you previously been notified that you would not be eligible for ill health benefits if appointed to the police service? If YES, please provide details.	**Yes** □	**No** □
Have you ever left a job or had to be medically retired due to ill health? If YES, please provide details.	**Yes** □	**No** □

Has any previous occupation caused you health problems? If YES, please provide details.	**Yes** □	**No** □
Are you in receipt of a medical pension or other disability benefit? If YES, please provide details.	**Yes** □	**No** □
Have you been on RECUPERATIVE, RESTRICTED or ADJUSTED duties at any time in the past three years?	**Yes** □	**No** □
Have you been referred to Occupational Health in the past three years?	**Yes** □	**No** □

Sickness Absence

Please list how many days you have been absent from work in the last three years. For each absence, please also state the dates and the reason. Continue on another sheet if required.

Please also send us a copy of your sickness record for the last three years from PSOP by taking a screenshot which includes your name, the dates and reasons i.e.;

PSOP > Employee Self Service > My Information > Absence

Or click on this link and select 'Absence' PSOP Employee Self Service

Number of days absence	Dates of absence (dd/mm/yyyy)	Reason(s). Please state if related to a disability

I hereby declare that the statements made by me on this medical questionnaire are true to the best of my knowledge and belief. I have fully disclosed all circumstances within my knowledge which concern my health.

Signed: …… Date: ……

Please return this form to Occupational Health as below;

OhMailbox-.Opt-in.PensionScheme@met.police.uk

Declaration
The information I have provided is accurate to the best of my knowledge and belief and I have not withheld any details. **I understand that giving false information or withholding information may result in my rejection or subsequent dismissal from the pension scheme or ineligibility to receive a pension or certain benefits under the scheme.** **I will notify you immediately if any of my answers change on my completed form.** **I consent to this data being held by Optima Health (the Occupational Health Unit of the**

Metropolitan Police Service) and stored on a computer or manual filing system, in accordance with the confidentiality requirements of the UK General Data Protection Regulation and Data Protection Act 2018.
Signature of applicant: * **Email Address:** **Date: ……**
***** **The receipt of this form from your personal e-mail replaces the requirement for a signature. Please indicate your personal email address in the signature line.**