MUTUAL BENEFIT FUND
AIR TRAFFIC CONTROLLERS

Health Declaration Form

MEDICAL HISTORY: Have you ever experienced or are you currently experiencing any of the following:

Eye or vision trouble?	Y	N	Diagnosed depression?	Y	N
Eye or corneal surgery?	Y	N	Anxiety disorder/panic disorder?	Y	N
Hay fever?	Y	N	Learning difficulty?	Y	N
Middle ear infection?	Y	N	Attention deficit or hyperactivity disorder?	Y	N
Sinusitis?	Y	N	Post traumatic stress disorder?	Y	N
Hearing trouble?	Y	N	Suicide attempt?	Y	N
Any other ears, nose & throat problems or surgery or dental issues?	Y	N	Any other mental illness or symptoms (including stress, depression or anxiety)?	Y	N
Problems with balance?	Y	N	Use of legal or illegal recreational drugs or substances?	Y	N
Asthma or wheezing?	Y	N	Substance dependence or substance abuse?	Y	N
Chronic cough?	Y	N	Muscle, bone or joint injury?	Y	N
Any other lung problem?	Y	N	Back pain, injury or "back trouble"?	Y	N
Any shortness of breath?	Y	N	Swollen or painful joints?	Y	N
Coughed or vomited blood?	Y	N	Suffered any pain severe enough to be disabling?	Y	N
Pulmonary embolism or deep vein thrombosis?	Y	N	Passed blood with or in urine or faeces?	Y	N
Any allergy?	Y	N	Kidney, bladder or prostatic disease?	Y	N
Heart problem?	Y	N	Easy fatigue-ability or sleep in the day?	Y	N
Vascular problem?	Y	N	Investigations for abnormal glucose tolerance, high blood sugar, or diabetes?	Y	N
Suffered any chest pain?	Y	N	Medical certificate for absence of 7 or more days from work?	Y	N
Rheumatic fever?	Y	N	Rejection or premium loading for life, health or loss of licence insurance?	Y	N
High or low blood pressure?	Y	N	Rejection or retirement from employment on medical grounds?	Y	N
Severe abdominal pain?	Y	N	Admission to hospital, psychiatric or in-patient facility?	Y	N
Hernia?	Y	N	Taken any type of medicine or medication or alternative medicine for more than 2 weeks?	Y	N
Oesophagus, stomach, liver, gall bladder or intestinal trouble?	Y	N	Had a positive laboratory test for HIV infection, or have you suffered from AIDS?	Y	N
Anaemia or blood disease?	Y	N	Sexually transmitted disease?	Y	N
Diagnosed or treated for cancer, tumour, growth or malignancy (including skin cancer)?	Y	N	Investigation for any disorder?	Y	N
Headaches/migraines which have interfered in any way with daily living?	Y	N	Any major medical or surgical procedure?	Y	N
Headaches/migraines requiring medication?	Y	N	Day surgery?	Y	N
Dizziness or fainting spells?	Y	N	Any other illness, disability, debility, infirmity, treatment or surgery or investigations?	Y	N
Unconsciousness for any reason?	Y	N			
Head injury?	Y	N	**Females only:**		
Seizures/fits/faint/collapse?	Y	N	Any troubling menstrual problems?	Y	N
Stroke?	Y	N	Other gynaecological problem?	Y	N
Paralysis?	Y	N	Any obstetric problem?	Y	N
Any other neurological disorder?	Y	N	Breast lump or other breast problem?	Y	N

If you answered "Yes" to any of the above questions, please provide all details of each instance - use extra pages or attach any documents as required

Please turn over for further questions

Has any medical certificate ever been denied, suspended or revoked within or outside of New Zealand?	Y	N
Has any assessment been deferred?	Y	N
Do you drink alcohol: If yes, how much do you drink per week (be specific)?	Y	N
Has a health professional ever expressed concern over your consumption of alcohol or have you ever been identified by a health professional as having a drinking problem, which might include the use of terms such as alcohol abuse, misuse or alcohol dependence?	Y	N
Have you ever received a conviction or formal caution for any alcohol or drug related behaviour including drink driving, public intoxication, or disorderly conduct?	Y	N
Has your alcohol consumption, or behaviour while under the influence of alcohol, ever led to a formal warning or other disciplinary procedure by your current or any past employer?	Y	N
Is any action against you pending, whether by the police or your employer, in respect of any alcohol or drug-related issue?	Y	N
Have you visited a health professional within the last three years (other than for a routine CAA medical or consultation with your certifying ME)?	Y	N
Are you aware of any symptoms signs or concerns regarding your health which should reasonably be investigated or reported to a health professional?	Y	N
Have you received any Notice under Section 27 I of the Civil Aviation Act (suspension, restriction, endorsements, etc)?	Y	N
Have you at any time been in receipt of a benefit from a loss of licence policy or other disability policy? If so, please supply details.	Y	N
Is there any other history of illness or health concern which might influence the acceptance of this application? If so, please supply details.	Y	N
Has a health professional ever expressed concern at your use of prescription or over the counter medications such as, but not limited to, those for pain relief, stress or sleep problems?	Y	N
Have you ever been diagnosed with a sleep disorder such as obstructive sleep apnoea syndrome?	Y	N
Are you aware of any symptoms, signs or concerns regarding your health which should be investigated or reported to a health professional?	Y	N
Family history: Have any members of your family had vascular disease, hypertension, diabetes, heart disease, psychiatric disease or neurological or other diseases (please mention age when condition discovered)? Mother Father Siblings Grandparents	Y	N

If you answered "Yes" to any of the above questions, please provide all details of each instance - use extra pages or attach any documents as required.

General Practitioner Contact Details:

Address é é é