FORM 11

EMPLOYEE'S HEALTH STATEMENT

NOTE : The purpose of this questionnaire is to give a general overview of your current physical condition and information on your medical history. The information disclosed will be used only to ensure that you have the medical qualifications required for the job you apply for. This information will determine whether you need a medical examination, but does not imply you will automatically have to submit to one.

LAST NAME : _____ **FIRST NAMES:** _____

ADDRESS : _____

DATE OF BIRTH : _____ **HEIGHT :** _____ **WEIGHT :** _____

WEIGHT ONE YEAR AGO : _____ **REASON FOR WEIGHT CHANGE** (If any) **:** _____

HISTORY

	YES	NO
Has one of your insurance applications ever been refused, changed or accepted with extra premium ?	[ ]	[ ]
Are you now, or have you ever been the recipient of disability or accident insurance benefits ?	[ ]	[ ]

Have you ever been treated for any of the following diseases or conditions or have you ever felt any of their symptoms ?

	YES	NO		YES	NO
Ear condition or deafness :	[ ]	[ ]	Migraines or severe headaches :	[ ]	[ ]
Alcoholism or drug addiction :	[ ]	[ ]	Cerebral or neurological disorders :	[ ]	[ ]
Allergies :	[ ]	[ ]	Intestine, stomach or liver disorders :	[ ]	[ ]
Arthritis or rheumatism :	[ ]	[ ]	Spinal disorders :	[ ]	[ ]
Cancer ou tumor :	[ ]	[ ]	Genital disorders :	[ ]	[ ]
Convulsions (epilepsy, unconsciousness) :	[ ]	[ ]	Visual disorders :	[ ]	[ ]
Diabetes :	[ ]	[ ]	Kidney or urinary tract disorders :	[ ]	[ ]
High blood pressure :	[ ]	[ ]	Blood vessel disorders :	[ ]	[ ]
Coronary deficiency :	[ ]	[ ]	Lung disorders :	[ ]	[ ]
Blood or gland disease :	[ ]	[ ]			
Nerve or mental disease :	[ ]	[ ]			

Do you have any physical abnormality or deformities ; do you suffer from a disease other than the above-mentionned diseases likely to affect your ability to perform the work related to the job applied for ? [Yes] [No]

If yes, explain : _____

Are you pregnant ? _____ If yes, when is the delivery expected : _____

Are you now regularly on prescription drugs ? ___

Do you receive medical care or treatment ? _____ Are you expected to receive some soon ? _____

If yes, explain : _____

	Cigarettes		Alcoholic beverages		Various drugs	
What is your weekly consumption of :	_____		_____		_____	
Did you use to take a larger amount ?	[Yes]	[No]	[Yes]	[No]	[Yes]	[No]

I declare that, to the best of my knowledge, the information given in this questionnaire is accurate and complete. I understand and accept that any misrepresentation or omission can result in the rejection of my application or the loss of my job or any benefit related to a pension or an allowance in connection with my health condition.

_____ Applicant's signature

_____ Date

Quebec Trucking Association