



PUBLIC SERVICE OF NAMIBIA HEALTH QUESTIONNAIRE

**THIS FORM MUST BE COMPLETED BY
ALL APPLICANTS**

FOR OFFICIAL USE

Accepted / rejected in accordance with directions

Signature:.....

Post designation:

Date:

OMA/RC:.....

A

1. Surname (in block letters):	5. Identity No.:
2. First Names:	
3. Age (years):	4. Height (cm):
6. Body mass (kg):	

B.

Are you suffering, or have you ever suffered from	Mark with a "X" in the appropriate column		If any answer is "Yes", give details of the nature, severity, date and duration of the illness
	Yes	No	
1. Any skin disease?		
2. Any condition affecting the skeleton and/or joints?	Yes	No
3. Any condition affecting the eyes, ears, nose or teeth?	Yes	No
4. Any condition affecting the heart or circulatory system?	Yes	No
5. Any condition affecting the chest or respiratory system?	Yes	No

Please turn over . . . /

Are you suffering, of have you ever suffered from	Mark with a "X" in the appropriate column		If any answer is "Yes", give details of the nature, severity, date and duration of the illness
	Yes	No	
6. Any condition affecting the digestive system?		
7. Any condition affecting the urinary system and/or genital or reproductive organs?		
8. Any condition affecting the nervous system or mental illness?		
9. Any other illness?		

C.

	Yes	No
1. Do you have any sensory impairment e.g. hearing, speech or sight?		
2. Do you have any disability? (physical, mental or any other impairment that substantially restricts you in one or other way of an individual's major life activities)		
IF YES, GIVE DETAILS OF THE NATURE AND SEVERITY OF THE DISABILITY:		

D.

Have you undergone any surgery/operation(s)?	Yes	No
IF YES, GIVE DETAILS OF THE NATURE AND DATE OF THE OPERATION(S)		

E.

I do hereby declare that the above information is true and correct and that I have not withheld any information regarding my health.

.....

Signature Date