Application for Ordination:

Medical Information Forms

This form is provided to an applicant seeking ordination as a minister in the Anglican Church of Australia. As part of the application process the Diocese is required to undertake due diligence as part of our screening processes to ensure that persons offering for this role are medically fit for the role and that the tasks of ministry work will not put their health at risk.

# Instructions to the applicant:

There are two forms:

Form 1: A self-declaration questionnaire to be completed by the applicant for discussion with their medical practitioner. Complete this form prior to seeing your doctor.

Form 2: Medical assessment of fitness to undertake the work of a minister

Make a long appointment with your regular doctor / clinic. The Diocese will reimburse any outstanding cost of this appointment. When you go to the appointment, you must take both forms with you:

* Form 1 – already completed by the applicant
* Form 2 – blank, ready for your Doctor to complete.

Persons who can complete Form 3:

Any doctor registered with the Australian Health Practitioners Regulation Agency, who is in a primary healthcare role and can reconcile the applicant’s medical history, medications and expected physical capacity with the requirements of the role, as outlined below.

After the appointment with your chosen Doctor, forward both forms to the Diocese:

* Form 1: Your Questionnaire,
* Form 2: The medical certification form which your Doctor will complete.

Once complete, the applicant shall forward the forms in an envelope marked confidential to:

The Leadership Pathways Director

Anglican Diocese of the NT

GPO Box 2950, Darwin, NT, 0801.

Forms will be stored as confidential by the Diocese, only to be accessed by authorised persons.

Form 1: Self-Declaration and Questionnaire:

# (to be completed by the applicant BEFORE your appointment with the Doctor)

Please attach additional sheets if you need more room.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_

Please list any significant PAST medical problems, operations or accidents that continue to have an impact on your ability to do the work of an ordained minister:

Please list any CURRENT medical problems which may impact your ability to do the work of an ordained minister:

Please comment on your mental health experience listing any clinically diagnosed depression, anxiety, stress disorder or any aspect of your mental health which may impact your ability to do the work of an ordained minister.

Weight: Has your weight changed significantly in the last 12 months?

 □ Yes (give details) □ No

Sleep: Do you have any problems with sleeping or excess fatigue?

 □ Yes (give details) □ No

Exercise: Please describe the type, intensity and frequency of exercise you regularly do:

Hearing: Do you have any hearing loss?

 □ Yes □ No (give details, including correction through

use of hearing aids)

Vision: Do you have impaired vision?

 □ Yes □ No (give details, including any correction by

spectacles)

Please list any medications you regularly take:

|  |  |  |
| --- | --- | --- |
| Medication | What is this medicine for? | Date you began taking this medicine |
|  |  |  |
|  |  |  |
|  |  |  |

Do you have any allergies?

 □ Yes (give details) □ No

Is there any other medical symptoms you experience that may impact on your ministry?

I declare that the information provided by me in this questionnaire is true and correct to the best of my knowledge.

Signature of applicant:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date:

Form 2: Pre-Ordination Assessment of Medical Fitness:

*(to be completed by the applicant’s medical practitioner)*

Who is eligible to complete this form?

Any doctor registered with the Australian Health Practitioners Regulation Agency, who is in a primary healthcare role and can reconcile the applicant’s medical history, medications and expected physical capacity with the requirements of the role, as outlined below.

Instructions for the Medical Practitioner:

Please complete this form, which will require you to undertake:

* a full clinical assessment of the patient, and
* review of the patient’s completed self-declaration (Form 1).

# Assessment of fitness to undertake the work of a minister:

* + - 1. I have conducted a clinical assessment of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name) in relation to their fitness to undertake the work of a minister
			2. Patient’s DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_
			3. This person has been a patient of this clinic since: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date)
			4. In conducting this assessment I had access to the patient’s past medical records

□ Yes □ No

*Please note: The fact that a candidate may not be able to carry out one or more of the functions normally required by a minister will not necessarily mean that he or she is not accepted. Consideration will be given as to whether reasonable adjustments could be made to enable the candidate to undertake the work of ordained ministry.*

1. Do you have any concerns about this patient’s capacity to do the work of an ordained minister? In particular, do you have any concern about:

|  |  |
| --- | --- |
| 3.1 The patient’s ability to project his/her voice in public speaking without amplification? |  Yes / No |
| 3.2 The patient’s ability to communicate effectively, orally and aurally? |  Yes / No |
| 3.3 The patient’s ability to communicate effectively in writing (manually and digitally) |  Yes / No |
| 3.4 The patient’s mental ability and agility as required for reflective thinking, theological study, engagement with members of the community and empathy in pastoral situations? |  Yes / No |
| 3.5 The patient’s personal mobility, adequate for travel to other communities and Diocesan church meetings? |  Yes / No |
| 3.6 The patient’s personal fitness to lead funerals and other pastoral services which are sometimes lengthy and may involve long periods of standing, inside and outside? |  Yes / No |
| 3.7 The patient’s capacity for planning and developing strategy? |  Yes / No |
| 3.8 The patient’s demonstrated emotional resilience and psychological robustness, especially in situations of conflict and uncertainty, both personal and communal? |  Yes / No |
| 3.9 The patient’s management of any relevant pre-existing health conditions, or any other concern regarding the impact of he /she taking on the work of a minister? |  Yes / No |

1. If you answered “yes” to any part of question 3 above, please give details below, including any limitations of your certificate of their medical fitness, noting which aspects of the role may need adjustment for this applicant. (*You may be contacted by the Diocese for further clarification. Please attach additional sheets if necessary.)*
2. A periodical medical review is required every

□ Not required □ 1 year □ 2 years □ 5 years

If periodic review is required in less than 12 months, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I have reviewed the self-declaration of this patient and am satisfied that it represents an accurate and adequate disclosure of relevant health information in relation to their application to work as a minister.

□ Yes □ No (please list any additional items)

*(Please turn over for declarations)*

# Declarations:

*Health Professional to complete:*

Name of Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address for further contact, if required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic contact details: (insert stamp or write address and phone number)

*(Patient to Complete in the presence of the Doctor)*

I  *(full name),\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

of, *(Address)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Do solemnly and sincerely declare that I have truthfully disclosed all relevant medical information relating to my health to the Health Professional for the purpose of conducting an assessment of my medical fitness to do the work of a minister and I make this solemn declaration by virtue of the *Oaths, Affadavits and Declarations Act 2010.*

I consent to Dr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(clinic) sharing any relevant medical information, including discussion of further details pertaining to this assessment with the Diocese for the purposes of determining my fitness to do the work of a minister, or any limitations or adjustments that would be needed for me to do that work without risk to my health.

(3) Signature Declared at ………………………the …..…….. day of …………… 20…

of the person

making the (3)

declaration

(4) Signature Before me,

of the person

before whom (4)

the declaration

is made

(5) Full name (5) Name of witness: …………………………………………………….

And contact

Number of

witness (5) Contact number of witness ……………………………………………

Note: This declaration may be made before any witness who is at least 18 years of Age.