Codladh Sámh

You Love : We Care

Fit For Work Evaluation Form

I, the undersigned Healthcare Assistant, give my consent to the undersigned General Practitioner to disclose any medical information which may affect my ability to perform the role of Healthcare Assistant with Codladh Sámh Teoranta, Castle Chambers, 6 Castle St, Cork.

Healthcare Assistant Name: ______________________________

Address Line 1: ______________________________

Address Line 2: ______________________________

Eircode: ______________________________

Telephone No: ______________________________

Signed by Applicant: ______________________ Date: ____________

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I ____________________ confirm and certify that I have medically examined the above-named person and I hereby declare her/him medically and physically fit to work as a Healthcare Assistant with Codladh Sámh Teoranta, Castle Chambers, No 6 Castle Street, Cork.

General Practitioner Name: ______________________________

Address Line 1: ______________________________

Address Line 2: ______________________________

Eircode: ______________________________

Telephone No: ______________________________

Signed: ______________________ Date: ____________

General Practitioner