

REVIEW OF INJURY AWARD
QUESTIONNAIRE

PERSONAL DETAILS

Full Name

Address

Phone Number

E-mail Address

Date of Birth

Date Left Force

Note: Please use the Continuation Sheet on page 4 as necessary

EMPLOYMENT SINCE LEAVING THE FORCE

A) Current Employment Situation

1. Are you currently
 - a) Employed yes / no
 - b) Self-employed yes / no
 - c) Unemployed but seeking work yes / no
 - d) Unemployed but not seeking work yes / no
 - e) Undertaking voluntary work yes / no
2. Name and address of your employer or business as applicable
3. Commencement date
4. Number of hours worked
5. Job title plus a brief description of duties undertaken
6. Please list the physical and mental requirements of the role e.g. driving, walking, lifting and bending
7. Current annual salary (excluding pension)
Gross Net

MEDICALLY RESTRICTED ONCE COMPLETE

8. Do you receive any other earned income? yes / no
If yes, please give details
9. Do you currently receive any State Benefits yes / no
If yes, please give details

NOTE: Re questions 7,8 and 9, please provide evidence of monies received

B) Previous employment or work activities undertaken since leaving the Force

1. Have you at any time previously been in employment or undertaken voluntary work since leaving the Force yes / no
2. If yes, please provide brief details of dates, employer, job title and salary earned

If no, please indicate the reason(s)

3. Please also provide brief details of any education or training undertaken

CURRENT MEDICAL CONDITION

1. Have your medical conditions changed since you left the Force or your injury award was last reviewed? yes / no

If yes, please give details including any treatments (e.g. operations, outpatient investigations or procedures) and current medication. Where possible, please also provide the details of any specialists to whom you have been referred.

MEDICALLY RESTRICTED ONCE COMPLETE

2. Are there any everyday activities you used to do, that as a result of your disability, you are no longer able to? yes / no

If yes, please provide details including dates of when you were last able to do these activities

3. Do you drive or ride a bike? yes / no

If yes, please give details of vehicle(s) plus an indication of weekly mileage

4. Please give details of any sporting activities you participate in

5. Are there any sports, hobbies or leisure activities you used to undertake but are no longer able to? yes / no

If yes, please provide details including dates of when you were last able to do them

ADDITIONAL INFORMATION

Please provide any additional information, not included in your replies, that you consider relevant to this review. If necessary, please attach any supporting documentation that you wish the Force Selected Medical Practitioner to consider.

DECLARATION

I declare that the information I have provided is accurate and correct to the best of my knowledge. I confirm that I have not knowingly withheld any relevant information.

Signed:

Dated:

AND FINALLY, PLEASE NOTE THAT;

- 1) Failure to provide full information relevant to the review may result in the Selected Medical Practitioner either making a determination based upon the facts and information available or declining to make a determination.
- 2) Once completed, please return, together with any additional documentation, to the Force Selected Medical Practitioner at the address given below marked 'Strictly Private & Confidential'.

SMP Address;

CONTINUATION SHEET (for your use as required)