

## CONSENT FORM: Wellness Medical Assessment

**FULL NAME:**

**DATE OF BIRTH:**

**NAME OF EMPLOYER:**

**HOME ADDRESS &  
TELEPHONE NO.:**

**Address:**

**Tel:** **Mob:**

**GENERAL PRACTITIONER  
DETAILS:**

**Name & Address:**

**Tel:**

### DECLARATION

Please read this declaration carefully, cross out the parts which do not apply to you and sign the form to confirm your consent:

- The nature of the Clear Health Ltd Wellness Medical Assessment has been explained to me.
- I do/do not consent for medical information to be disclosed to my employer if they request it.
- I would/would not like the Clear Health Ltd Doctor to forward my information to my G.P

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

**Please post this form to:**

**Clear Health Ltd  
1-2 Universal House,  
88-94 Wentworth Street,  
London E1 7SA**