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**CANDIDATES PACK 2025**

**FOR ORDAINED MINISTRY TRAINING**

Medical Report

Due 4th August 2025

To: Te Hāpai Ō Ki Muri

Private Bag 11-903

Ellerslie

AUCKLAND 1542

Ph: (09) 5254179

Email: [admin@tehapai.org.nz](mailto:admin@tehapai.org.nz)

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| **TO THE CANDIDATE:** |
| This medical report will be read by an independent medical professional who will provide a summary of it to Te Hāpai Ō Ki Muri. This form or just the summary may be provided to the Candidates’ Assessment team and Directors of Te Hāpai Ō Ki Muri if required for further clarification. See the Candidates Handbook for further explanation about health and ministry candidates. If you are accepted as a candidate, the medical report will become part of your file.  Please note:   * All costs are to be carried by the Candidate * You must complete the below section before giving it to your doctor   This must be completed and returned to Te Hāpai Ō Ki Muri by **Monday 4th August 2025** |

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| **TO THE MEDICAL PROFESSIONAL:** |
| The person who gave you this form is applying to work in the Methodist Church of New Zealand.  The purpose of this report is to ask for your comments on the overall health of the Candidate, particularly as it relates to the requirements of ministry and work in the church.  Please be frank and honest in your comments.  Please complete this form using a black ballpoint pen and return it to the candidate as soon as possible. The form can also be sent directly to Te Hāpai Ō Ki Muri (Private Bag 11 903 Ellerslie, Auckland 1542 - marked Private and Confidential).  **Ministry within the Church can be physically and psychologically demanding:**   * Irregular work hours * Long periods of standing or sitting * Being away from home, travelling, eating at unusual hours * Studying, reading and writing * Pressure of working with people in grief situations, crisis, illness, etc. * Isolation, geographically and collegially * Meeting the demands and expectations of others   With these areas of stress and pressure in mind, please complete the following report. |

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| **Please note:** |
| During the course of the candidate’s application process this medical form will be read by:   * The Te Hāpai Ō Ki Muri Staff overseeing the Candidates Process. * An independent Medical professional who will provide a summary of it for the Candidates’ Assessment Team. * A copy of the independent Medical Professional’s summary is provided to the Candidate if required. |

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| **SECTION ONE**  Details are to be completed by the Candidate before attending the Medical Examination. Please also complete the disclosure below | | |
| 1.1 | Candidates name |  |
| 1.2 | Date of Birth |  |
| 1.3 | Phone number |  |
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| **SECTION TWO**  Details are to be completed by the Medical Examiner in the presence of the Candidate | | |
| 1.4 | Medical Examiner | |
|  | Name |  |
|  | Phone number |  |

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| **DISCLOSURE** |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name applicant) agree to the full disclosure to The Methodist Church of New Zealand’s National Candidates Assessment Team by the above named Doctor of any details he/she deems appropriate to my candidating for ministry.  Signed by (Applicant): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signed by (Doctor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Note:  The candidate is responsible for payment  to his/her GP for this medical examination  (All costs are to be carried by the Candidate / Applicant) |

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| 1. **HISTORY** | | | | | | |
| 2.1 | Family History | | | | | |
| Relation | | LIVING | | DEAD | | |
| Age | State of Health | Year | Age | Cause of Death |
| Father | |  |  |  |  |  |
| Mother | |  |  |  |  |  |
| Brothers | |  |  |  |  |  |
| Sisters | |  |  |  |  |  |

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| 2.2 | Is there any history of: Please tick in appropriate box | | | | | |
| 1. Heart disease or hypertension? | |  | Yes |  | No |
| 1. Asthma or bronchitis? | |  | Yes |  | No |
| 1. Disorders requiring maintenance therapy? | |  | Yes |  | No |
| 1. Gastro-intestinal disorders? | |  | Yes |  | No |
| 1. Renal disorders? | |  | Yes |  | No |
| 1. Rheumatoid or other arthritis? | |  | Yes |  | No |
| 1. Epilepsy or other neurological disease? | |  | Yes |  | No |
| 1. Nervous breakdown or mental illness? | |  | Yes |  | No |
| 1. If Female: Obstetrical or gynaecological disorder? | |  | Yes |  | No |
| 1. Surgical operation(s)? | |  | Yes |  | No |
| 1. X-ray, other investigation or referral to a specialist in the last 3 years? | |  | Yes |  | No |
| 1. Any other significant disorders? | |  | Yes |  | No |
| Comments / explanations | | | | | |
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| 2.3 | Has the candidate had any of the following symptoms within the last year? | | | | | |
| 1. Chest pain? | |  | Yes |  | No |
| 1. Shortness of breath? | |  | Yes |  | No |
| 1. Change in weight? | |  | Yes |  | No |
| 1. Undue anxiety or depression? | |  | Yes |  | No |
| Comments / explanations | | | | | |
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| 2.4 | Has the applicant ever resided overseas?  If Yes, please give details below | |  | Yes |  | No |
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| 2.5 | What is the applicants consumption of: | | | | | |
| 1. Alcohol |  | | | | |
| 1. Tobacco |  | | | | |

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| 1. **EXAMINATION**   Note: If the answer to any question in Part II is NO, please give details or attach a report. | | | | | | |
| 2.6 | Appearance: | | | | | |
| 1. Are build and appearance normal? | |  | Yes |  | No |
| 1. Does endocrine (including thyroid) function appear normal? | |  | Yes |  | No |
| 1. Do lymph nodes appear normal? | |  | Yes |  | No |
| 1. Do bones and joints appear normal? | |  | Yes |  | No |
| 1. Does skin appear normal? | |  | Yes |  | No |
| Comments / explanations | | | | | |
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| 2.7 | What is the applicants: | | | | | |
| 1. Height |  | | | | |
| 1. Weight |  | | | | |

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| 2.8 | Cardiovascular System: | | | | |
| 1. Is the heart normal to percussion and auscultation? |  | Yes |  | No |
| 1. Is the position of the apex beat normal? |  | Yes |  | No |
| 1. Is the pulse normal in rate? |  | Yes |  | No |
| 1. Is the pulse normal in volume? |  | Yes |  | No |
| 1. Is the pulse normal in rhythm? |  | Yes |  | No |
| 1. Do the arteries seem normal? |  | Yes |  | No |
| 1. Blood pressure: |  | | | |
| * What is the systolic pressure? |  | | | |
| * What is the diastolic pressure (5th phase)? |  | | | |
| Comments / explanations | | | | |
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| 2.9 | Respiratory System: | | | | |
| 1. Is the chest normal in shape? |  | Yes |  | No |
| 1. Are the lung fields free from abnormal physical signs? |  | Yes |  | No |
| Comments / explanations | | | | |
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| 2.10 | Alimentary System: | | | | |
| 1. Are the mouth, teeth, nose and throat healthy? |  | Yes |  | No |
| 1. Are the abdominal organs normal? |  | Yes |  | No |
| 1. Are the hernia orifices normal? |  | Yes |  | No |
| Comments / explanations | | | | |
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| 2.11 | Genito-Urinary System: | | | | |
| Is the urine free from abnormal constituents? |  | Yes |  | No |
| (If Female) |  |  |  |  |
| 1. Is the uterine function apparently normal? |  | Yes |  | No |
| 1. Are the breasts healthy? |  | Yes |  | No |
| 1. Date of last cervical smear |  | | | |
| Comments / explanations | | | | |
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| 2.12 | Central Nervous System: | | | | |
| Are the reflexes normal: |  |  |  |  |
| 1. Pupillary light reflex? |  | Yes |  | No |
| 1. Upper limbs? |  | Yes |  | No |
| 1. Lower limbs? |  | Yes |  | No |
| Comments / explanations | | | | |
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| 2.13 | Speech: | | | | |
| Is speech normal? |  | Yes |  | No |
| Comments / explanations | | | | |
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| 2.14 | Psychological Assessment: | | | | |
| Does the applicant seem free from neurosis (obsession, depression, anxiety, etc) and from psychosis and other disorders of personality and behaviour? |  | Yes |  | No |
| Comments / explanations | | | | |
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| 2.15 | Special Senses: | | | | | | | |
| 1. Does the applicant wear spectacles? | | |  | Yes | |  | No |
| 1. What is the visual acuity (with spectacles if worn)? | | |  | | | | |
| * Left | | |  | | | | |
| * Right | | |  | | | | |
| 1. Are both visual fields unimpaired? | | |  | Yes | |  | No |
| 1. Are both optic fundi normal? | | |  | Yes | |  | No |
| 1. Are the ears free from disease? | | |  | Yes | |  | No |
| 1. Is the hearing normal? | | |  | Yes | |  | No |
| If the answer to any question in Part II is NO, please give details or attach a report | | | | | | | |
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| 2.16 | | Blood tests: | Normal | | | Results attached | | |
| 1. CBC |  | | |  | | |
| 1. Ferritin |  | | |  | | |
| 1. HIV |  | | |  | | |
| 1. Hepatitis B |  | | |  | | |
| 1. Creatinine |  | | |  | | |
| Comments / explanations | | | | | | |
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| 1. **DECLARATION** | | | | | | |
| 2.16 | From your examination, is there any indication of significant disease or cause for concern? | |  | Yes |  | No |
| 2.17 | Is there any indication for further investigation? | |  | Yes |  | No |
|  | If YES, to either 2.16 or 2.17 please give details | | | | | |
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| 2.18 | Would you like the Church’s Medical Advisor to contact you about this applicant? | |  | Yes |  | No |
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| 2.19 | Medical Practitioner details | | | | | |
|  | Name |  | | | | |
|  | Qualifications |  | | | | |
|  | Address |  | | | | |
|  | Signed |  | | | | |
|  | Date of Examination |  | | | | |
|  | Official Stamp |  | | | | |

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| Please return this form to Te Hāpai Ō Ki Muri by the Friday 28th March 2025 with a copy to the Candidate.  Candidates Assessment  Te Hāpai Ō Ki Muri  Private Bag 11 903  Ellerslie  Auckland 1542 | | |
| **SECTION THREE**  To be completed by the Medical Advisor appointed by Te Hāpai Ō Ki Muri | | |
| 3.1 | Are there any medical conditions or any aspects of this person’s medical history (present or past) of which the National Candidates Assessment Team or Trinity College need to be aware, which may affect the ability of the applicant to study intensively or participate in ministry long term (see page 2 of the application for a description of this). | |
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| 3.2 | If there are any concerns, what would you advise that the applicant do in order to be able to fulfil these requirements? | |
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| 3.3 | What further means of assistance should be sought by the applicant? | |
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| 3.4 | Any other comments | |
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|  | | |
|  | Medical Advisor - Signed |  |
|  | Email address |  |
|  | Date |  |
|  | Candidates Name:  Email address: |  |