HarrowHealth CIC

CONFIDENTIAL PRE-EMPLOYMENT HEALTH QUESTIONNAIRE

Please complete all sections as requested. The organisation treats personal data collected in this medical questionnaire in accordance with its GDPR and Data Protection Policy Employee Privacy Statement on processing special categories of personal data. The Privacy Statement also contains information about how data is used and the basis for processing the data.

Please complete and return this form to our confidential HR Inbox: HARL.HR@nhs.net

Surname ______ Former Name (if applicable) ______

First Name(s) ______ Male/Female ______

Title : Mr/Mrs/Ms/Miss/Dr Date of Birth / /

Home Address ______

Postcode ______

Contact telephone ______ Email address ______

Job Interviewed For ______ Start Date ______

Hours - Full Time/Part Time Hrs per week ______

Does your Job Description detail that you will carry out the following duties?	Please indicate:	Have you been advised not to carry out any of these duties for medical reasons? If so, please give details:
Manual Handling such as bending/lifting, carrying		
Providing hands on patient care		
Lone Working/working in confined spaces		
Computer work		
Shift/Night work		
Working with potential hazards or materials		
Operating machinery/Driving significant distances		

Please provide information regarding any of the declared conditions below, using an additional sheet of paper if necessary:

1. Do you need any special aids/adaptations to assist you at work whether or not you have a disability? The meaning disability as defined by the Disability Discrimination Act, is “a physical or mental impairment which has a substantial and long term adverse effect on your ability to carry out normal day to day activities?” ***Yes/No***

If yes please give details ______

2. Do you have any back problems or other musculo-skeletal problems which will cause difficulty with bending, sitting, lifting or standing for long periods? ***Yes/No***

Please give details, including any periods of absence ______

3. Do you have a history of anxiety, depression, psychiatric disorder, stress related problems, eating disorders, drug/alcohol misuse, self harm or overdose? ***Yes/No***

Please give details below, including dates, any periods of absence & treatment

____

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4. Do you take any regular prescribed medication? ***Yes/No***

If yes, please list medication & reason: ____

5. Do you have any skin conditions, dermatitis, allergies to skin cleansing products, latex or other glove problems? ***Yes/No***

Please give details ____

6. Have you, at any time, experienced fits, faints or blackouts? ***Yes/No***

Please give details including dates and treatment ____

7. Have you ever had a positive test for any blood borne virus that could be transmitted by a contamination incident, e.g. HIV, Hepatitis A, B or C? ***Yes/No***

Please give details ____

8. Have you ever been ill health retired or received compensation for an industrial injury? ***Yes/No***

Please give details ____

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9. Do you have or have you suffered with any health issues regarding your chest, heart or respiratory system including Tuberculosis? ***Yes/No***

Please give details ____

10. Have you ever been diagnosed with Diabetes? ***Yes/No***

Please give details ____

11. Have you ever had chicken pox or shingles, measles or similar ailments? ***Yes/No***

Please give details ____

12. Have you been under the care of a hospital/specialist consultant or had any hospital admission in the last 3 years. ***Yes/No***

Please give details ____

Please list all periods of absence from work in the last 2 years

<u>Reason:</u>	**Days Absent:**

To be completed ONLY if you will be working in with patient contact/with clinical materials:

Immunisation record:

Not all of these immunisations will be relevant to your work but please complete what you can. Please note that we may need you to contact your GP for your immunisation record, otherwise you may be required to undertake these tests/vaccinations again.

	Please tick as appropriate	**Date**	**Booster due (if applicable)**
Have you been immunised against Diptheria?	☐ Yes ☐ No		
Have you been immunised against Tetanus?	☐ Yes ☐ No		
Have you been immunised against TB?	☐ Yes ☐ No		
Have you been received a BCG immunisation?	☐ Yes ☐ No		
Have you been immunised against Chicken Pox?	☐ Yes ☐ No		
Have you been immunised against Hepatitis A, B, or C?	☐ Yes ☐ No		
Have you been immunised against Influenza?	☐ Yes ☐ No		
Have you been immunised against Measles, Mumps and Rubella?	☐ Yes ☐ No		

DECLARATION: I declare that the information on the form is true and complete. I understand that if I omit any information I may be subject to disciplinary action up to and including dismissal. I am prepared to undergo a medical examination if required. Disclosure of medical information to the examining Doctor by my present medical practitioner and any other who have examined me may be necessary and in these circumstances my permission will be sought in accordance with the Access to Medical Report Act 1988.

Signature:……………………………………………………. Date: ……………………………

HR: Signed Fit commence employment		Date:	
OR: Occupational Health referral needed		Date:	