The purpose of this questionnaire is not to exclude you from work but to see whether you have any health problems that may require support/equipment to enable you to work and to ensure that we do not place you at risk in the workplace. Your answers to this questionnaire will be **CONFIDENTIAL** to the Occupational Health team and will not be given to anyone else without your written permission. An occupational health specialist may wish to speak to you about your health to determine what support you may need.

**We always treat the information you give us as medically confidential.  No clinical details will ever be released to anyone outside Occupational Health without your consent. However, we will use the information you provide, to give simple advice about your fitness for work (e.g. fit/unfit) and by signing this form, we will assume that you consent to us doing this.**

Please follow the instructions below which are based on your role.

1. **NON-PATIENT CONTACT ROLES**

• ***ALL APPLICANTS TO COMPLETE THE CONTACT DETAILS ON PAGE 2***.

• If your role is non-patient contact, e.g. office based, administration, secretarial, HR, Payroll, IT, Catering, etc., then complete the contact details on page 2, Section 1 and TB questionnaire on page 3.

• If you have answered **NO** to all the questions, with the exception of the question "Have you ever had Chickenpox?" please return the form to the **Recruitment Team (**[**recruitment@york.nhs.uk**](mailto:recruitment@york.nhs.uk)**)**

• If you have answered **YES** to any question, please provide details and **return the form to the Occupational Health & Wellbeing Service address above to maintain your confidentiality.**

1. **PATIENT CLINICAL CONTACT ROLES**

• ***ALL APPLICANTS TO COMPLETE THE CONTACT DETAILS ON PAGE 2.***

• This would include:

a) Nurses, doctors, radiographers, physiotherapists, occupational therapists, pharmacists and all roles where physical contact with patients is the norm.

b) Those involved in Exposure Prone Procedures, e.g. some Nurses, Midwives, Doctors, etc.

c) Those involved in the handling of body fluids, either to transport them, clean them up or handle them in a laboratory environment, e.g. this includes all LLP involved in these tasks, ward-based housekeepers, clinical scientists/doctors in Pathology, etc.

• Complete Sections 1 and 2. **Please return the form to the Occupational Health & Wellbeing Service address above to maintain your confidentiality.**

**If in doubt complete all sections, including the contact details on page 2 and return the form to the Occupational Health & Wellbeing Service address above to maintain your confidentiality.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **TO BE COMPLETED BY RECRUITMENT TEAM OR MEDICAL STAFFING** | | | | |
| **Recruitment Team:** | | | **Fitness to Work Certificate to be sent to:** | |
|  | | | TRAC or Manager arranging a student placement | |
| **In certain areas specific hazards require health surveillance for staff protection prior to commencement. Please discuss with Occupational Health if there are queries or further details required regarding this.** | | | | |
| **NHS Risk Exposure Category** (see Managers' Guidance) | | | | **Please enter exposure category (1-5)** |
| **The job involves occupational exposure to:** | **Yes** | **No** | | **Details** |
| (a) Respiratory irritants |  |  | |  |
| (b) Exposure to noise over 80db |  |  | |  |
| (c) Latex |  |  | |  |
| (d) Cytotoxic agents |  |  | |  |
| (e) Fumes |  |  | |  |
| (f) Solvents |  |  | |  |
| (g) Working at night |  |  | |  |
| (h) Working at heights |  |  | |  |
| (i) Food handling |  |  | |  |
| (j) Working alone |  |  | |  |
| (k) Shift work |  |  | |  |
| (l) Other workplace exposure –please specify |  |  | |  |

Please complete this form in **BLACK** pen/typeface and block capitals.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **TO BE COMPLETED BY ALL APPLICANTS** | | | | |
| Title (Mr/Ms/Miss/Mrs/Dr/Prof): Male  Female | | Date of Birth: | | |
| Surname/Family Name:  Previous Names (if applicable): | | First name: | | |
| Proposed Job Title: | | Appointing Manager: | | |
| Department: | | Home Address:  Post Code: | | |
| Tel: Home:  Mobile:  E-Mail Address: | | Contact details (preferred method of contact):  Tel / Mobile / E-mail | | |
| If you already work for the Trust, including on the  Bank, please state your current job title: | | If you are completing this form as an existing member of staff looking to join the Bank, please indicate if you intend to accept shifts in the following specialities:  Theatres  Renal  A&E  Midwifery | | |
| **FOR OCCUPATIONAL HEALTH USE ONLY. THE ABOVE NAMED HAS BEEN FOUND:** | | | | |
| Fit for post **(EPP)** **🞎** Fit for post **(non-EPP)** 🞎 Unfit for post 🞎 Awaiting further information 🞎  Safety plan required (contact OH upon start date) 🞎  Fit with restriction **🞎** details ………………………………………………………………………………………………………………. | | | | |
| **VACCINATION UPDATE REQUIRED DURING FIRST WORKING WEEK?**  (Prior to attendance at Occupational Health, please ensure a risk assessment has been undertaken before proceeding to patient contact to avoid transfer of infectious disease, e.g. Hepatitis B, Rubella, Measles, TB, Chickenpox, etc.) | | | | **YES/NO** |
| **HEALTH SURVEILLANCE REQUIREMENTS BY MANAGER**   * 6-WEEK SKIN CHECK * NIGHT WORKER ASSESSMENT REQUIRED EVERY 2 YEARS * OTHER ……………………………………………………………………… | | | | **🞎**  **🞎**  **🞎** |
| **Equality Act (2010) may apply in this case** | | | | **YES/NO** |
| **Assessed by:**  Name:  Signature: | **Designation:**  **OHP / SOHA / OHA** | | **Date:** | |

**SECTION 1: TO BE COMPLETED BY ALL APPLICANTS (PLEASE REFER TO THE GUIDANCE ON PAGE 1)**

**Please ensure you have completed your contact details on page 2**

YES NO DETAILS Use an additional sheet of paper if required

|  |  |  |  |
| --- | --- | --- | --- |
| Do you have any physical or mental problem or condition which affects your ability to work or carry out normal day to day activities? |  |  |  |
| Are you currently receiving advice or treatment from your GP or any other medical specialist (consultant, physiotherapist, psychologist, counsellor, CMHT, etc.) for any condition including repeat prescriptions for stable conditions excluding contraception? |  |  |  |
| Are you waiting for investigation or treatment at the moment? |  |  |  |
| Do you suffer from any long term or recurrent medical condition? |  |  |  |
| Have you ever left or changed a job for medical reasons? |  |  |  |
| Do you consider that you require any adjustments to enable you to fulfil this role? |  |  |  |
| Do you have any allergies or sensitivities (including food, latex)? |  |  |  |

**TB**

|  |  |  |
| --- | --- | --- |
| Do you have any of the following: | Yes/No | Please give details |
| Cough that lasted more than 3 weeks, coughing up blood, unexplained weight loss or unexplained fever? |  |  |
| Have you been in close contact with anyone diagnosed with or suspected of having TB? |  |  |
| Have you lived outside of the UK for more than 3 consecutive months in the last 5 years? |  |  |

### Skin/Respiratory

|  |  |  |
| --- | --- | --- |
| Do you have or have you ever had, any of the following? | Yes/No | Details (dates/treatment) |
| 1. Skin problems? E.g. eczema, psoriasis, dermatitis, lesions, itching, bleeding cracking, weeping, urticaria |  |  |
| 1. Rhinitis, sneezing, coughing, runny nose, itchy or runny eyes? |  |  |
| 1. Taking any medications for a skin condition? |  |  |

### DECLARATION

I declare that the answers to the above questions are true and complete to the best of my knowledge and belief.

|  |  |
| --- | --- |
| Name (Block Capitals):  Proposed Job Title:  Signed: | Date: |

**SECTION 2:**

**TO BE COMPLETED BY ALL PATIENT CONTACT STAFF (PLEASE REFER TO THE GUIDANCE ON PAGE 1)**

**Please ensure you have completed your contact details on page 2**

|  |
| --- |
| **HEPATITIS B** |
| Have you ever had or tested **POSITIVE** for Hepatitis B? Yes  No |
| **Please attach copies of your immunisation history with this form from your GP or previous occupational health service. Please note that if you are a new starter with the Trust evidence of your Covid-19 vaccination will be checked by your Recruitment Advisor.** |
| |  |  |  | | --- | --- | --- | |  | **Date of vaccination/blood test** | **Comment** (e.g results) | | BCG |  |  | | Diphtheria/Tetanus/Polio |  |  | | Hepatitis B vaccine |  |  | | Hep B Surface antibody |  |  | | Hep B Surface Antigen |  |  | | Hep C |  |  | | HIV |  |  | | Influenza (latest vaccination only) |  |  | | Meningitis |  |  | | MMR (measles, mumps, rubella) |  |  | | Measles blood test |  |  | | Rubella blood test |  |  | | TB skin test (Heaf,Mantoux) |  |  | | Chickenpox |  |  | | Have you ever had chickenpox? |  |  | |

**STAFF INVOLVED IN EXPOSURE PRONE PROCEDURES (EPP)**

EPP are those procedures where the worker’s gloved hands may be in contact with sharp instruments, needle tips or sharp tissue (e.g. spicules of bone or teeth) inside a patient’s open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times. Staff who undertake EPPs include all surgeons (including FY1 and FY2 doctors with a rotation into one of the EPP areas), dental staff, theatre staff, midwives, A&E doctors and nurses. Renal Unit staff must also provide documentary evidence of Hepatitis B status.

|  |  |
| --- | --- |
| **Yes (please give details)** | **No** |
| **Will you be performing Exposure Prone Procedures? (see above for definition of EPP)** |  |  |
| **Will you be working in the Renal Unit?** |  |  |

**Healthcare workers who perform EPPs have an ethical duty to inform the OH team if they suspect or know that they are infectious carriers of HIV, Hepatitis B or Hepatitis C.**

EPP staff ***MUST*** provide documentary evidence of negative infection status or immunity following vaccine to Hepatitis B/C and HIV status. This must be an **identified validated sample** (IVS). Health clearance for EPP work cannot be given until these results have been received by the Occupational Health team.

If you are unable to provide evidence we will offer testing in this department. You will be asked to show photographic identification, i.e. valid driver’s licence, passport or hospital ID, for this procedure. This is to comply with the Department of Health’s standard for identified validated samples.

### Copies of results should be in one of the following formats and must state your name, date of birth and be signed and dated by the General Practitioner/Occupational Health Service with verifiable signatures and contact numbers.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **UK Laboratory Report** | Enclosed  **YES / NO** | **Typed letter from General Practitioner (must show GP letterhead)** | Enclosed  **YES / NO** | **Occupational Health Department letter/or certificate** | Enclosed  **YES / NO** |

### DECLARATION

I declare that the answers to the above questions are true and complete to the best of my knowledge and belief.

|  |  |
| --- | --- |
| Name (Block Capitals):  Proposed Job Title:  Signed: | Date: |