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.

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 and Section 1 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 **HR Support Team**

• 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. porters, ward-based housekeepers/domestic assistants, clinical scientists/doctors in Pathology, etc.

• Complete Sections 1 and 2 and **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 HR SUPPORT TEAM OR MEDICAL STAFFING** |
| **HR Support Team:**  | **Fitness to Work Certificate to be sent to:** |
|  | Medical Staffing (Medical Staff Recruitment only) |
| **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** (Infectious Disease - 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 help us to help you by completing the questionnaire as fully as possible. 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 [ ]  Gynae Ward [ ]  A&E |
| **FOR OCCUPATIONAL HEALTH USE ONLY. THE ABOVE NAMED HAS BEEN FOUND:** |
| Fit for the post as described  |  | **HEALTH ASSESSMENT / VACCINATION UPDATE REQUIRED DURING FIRST WORKING WEEK?** | **YES/NO** |
| Fit with restrictions |  | **Requires Health Surveillance update** | **YES/NO** |
| Unfit for post |  | **Requires immunisation update** to ensure they are protected against the relevant infectious diseases. 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** |
| Can Work **EPP/Non-EPP** |  |
| Awaiting further information |  | **Equality Act (2010) may apply in this case** | **YES/NO** |
| Restrictions/additional information:  |
| **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 illness/impairment or disability which may affect your ability to do your job? If yes, please provide details. |  |  |  |
| Have you ever had any mental health illness/impairment/disability, e.g. stress/depression/anxiety/diagnosed mental health condition that may affect your ability to do your job? If yes, please provide details.  |  |  |  |
| Are you having treatment or investigations at present? If your answer is yes, please provide further details of the condition, treatment and dates. |  |  |  |
| Do you think you may need any adjustments/equipment or assistance to help you to do your job? If yes, what do you need? |  |  |  |

|  |
| --- |
| **The following questions relate to the prevention and control of Tuberculosis (NICE guidance 2006) and Department of Health guidance on infectious disease in Health Care Workers**Do you have any of the following: **YES NO YES NO** |
| A cough which has lasted for more than three weeks? |  |  | Unexplained weight loss? |  |  |
| Unexplained fever?  |  |  | A personal history of Tuberculosis? |  |  |
| A family history of Tuberculosis?   |  |  | Other chest complaint? |  |  |
| Have you ever had Chickenpox? |  |  | Can you provide documented evidence of immunity to measles? |  |  |
| Can you provide documentary evidence of immunity to Rubella? |  |  | Have you been abroad for 3 consecutive months or more during the last 5 years. **If yes, where have you visited?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |

### 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 [ ]  |
| Have you had a course of Hepatitis B vaccine? Yes [ ]  No [ ]  |
| Please provide details of Hepatitis B vaccination course and any subsequent boosters:

|  |  |
| --- | --- |
| Date of 1st Hep B vaccine |  |
| Date of 2nd Hep B vaccine |  |
| Date of 3rd Hep B vaccine |  |
| Date of blood test to check immunity and result |  |
| Date of 5 year booster of Hep B vaccine |  |

 |

**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?** |  |  |
| **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: |