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| **Confidential Workplace Health & Wellbeing Pre-Placement Form**  **For Non-Healthcare Workers**  **Revision Date: June 2020** |
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| **PART 1 - Recruiting Officer to Complete** |

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| Employer name & address |  | | |
| Job Title |  | | |
| Department/Area |  | Job Ref |  |
| Recruiting Officer & telephone number |  | Recruiting email address to return outcome report |  |
| Substantive  Temporary  Bank / Locum | | | |
| FT/PT (if PT state hours) |  | Start date |  |

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| **Hazard Categories – Please tick all that apply to this job role** | | | | | | | | | | |
| Manual Handling | | |  | | |  | Prevention of Management of Aggression | | |  |
| Night working / Shift work | | |  | | |  | Crouching / Stooping or Kneeling | | |  |
| VDU User | | |  | | |  | Frequent Hand washing / Wearing gloves | | |  |
| Driving of Patients | | |  | | |  | Chemical sensitisers | | |  |
| Hand arm vibration / power tools | | |  | | |  | Noise | | |  |
| Blood / Body Fluid Exposure | | |  | | |  |  | | |  |
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| **PART 2 - Applicant to Complete** | | | | | | | | | | |
| Please note: Your answers to this questionnaire will remain confidential to the Workplace Health & Wellbeing team and will not be given to anyone else. The purpose of the questionnaire is to see whether you have any health problems that could affect your ability to undertake the duties of the post you have been offered or to advise on any adaptations or modifications that may be required to assist you in performing the tasks of the job. In addition, we wish to ensure that you will not be placed at risk in the workplace and to help identify if there is a risk of developing work related illness from any health hazards in the post. An appointment with an Occupational Health Adviser or Physician may be required following receipt of this questionnaire.  Please ensure you answer all questions as full as possible. Failure to complete this questionnaire will result in a delay to your health clearance and subsequent start date. | | | | | | | | | | |
| **SECTION A: Personal details** | | | | | | | | | | |
| Surname |  | | | | | | | | | |
| First names |  | | | | | | | Title |  | |
| Date of birth |  | | | | | | | | | |
| Home address |  | | | | | | | | | |
| Home telephone |  | | | | | | | | | |
| Mobile telephone |  | | | | | | | | | |
| Email address |  | | | | | | | | | |
| **SECTION B: Medical Information** | | | | | | | | | | |
| Do you have a health condition or disability (physical or psychological) which could cause you any difficulties in undertaking the job you have been offered? | | | | | | | | | | |
| Yes ☐ | No ☐ | | | If yes, please give details: | | | | | | |
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| Do you think that you may require special adjustments or certain equipment in order to complete the tasks of the job? | | | | | | | | | | |
| Yes ☐ | No ☐ | | | If yes, please give details: | | | | | | |
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| Have you ever had any health condition / impairment / disability which may have been caused or made worse by your work? | | | | | | | | | | |
| Yes ☐ | No ☐ | | | If yes, please give details: | | | | | | |
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| Are you taking any regular prescribed medication? | | | | | | | | | | |
| Yes ☐ | No ☐ | | | If yes, please give details: | | | | | | |
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| Are you having or waiting for treatment or investigations at present? | | | | | | | | | | |
| Yes ☐ | No ☐ | | | If yes, please give details: | | | | | | |
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| Have you ever been treated for Mental Health problems (including anxiety, depression, eating disorders, alcohol or drug abuse?) | | | | | | | | | | |
| Yes ☐ | No ☐ | | | If yes, please give details: | | | | | | |
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| Musculoskeletal problems including any difficulties in standing bending lifting or other movements (back pain, arthritis, pains in upper limbs, lower limbs, neck, shoulder) | | | | | | | | | | |
| Yes ☐ | No ☐ | | | If yes, please give details: | | | | | | |
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| Skin problems (including eczema, dermatitis, or associated allergies (e.g. latex) | | | | | | | | | | |
| Yes ☐ | No ☐ | | | If yes, please give details: | | | | | | |
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| Do you have hearing difficulties or ear problems? | | | | | | | | | | |
| Yes ☐ | | No ☐ | | | If yes, please give details: | | | | | |
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| Do you have any chest problems, breathing difficulties, Asthma, wheezing or recurrent bronchitis? | | | | | | | | | | |
| Yes ☐ | | No ☐ | | | If yes, please give details: | | | | | |
|  | | | | | | | | | | |
| Do you have any heart or circulation problems or high blood pressure? | | | | | | | | | | |
| Yes ☐ | | No ☐ | | | If yes, please give details: | | | | | |
|  | | | | | | | | | | |
| Do you have epilepsy, fits, blackouts or recurrent dizziness? | | | | | | | | | | |
| Yes ☐ | | No ☐ | | | If yes, please give details: | | | | | |
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| Do you have diabetes? | | | | | | | | | | |
| Yes ☐ | | No ☐ | | | If yes, please give details: | | | | | |
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| Do you have any medical conditions that prevent you working safely at night? | | | | | | | | | | |
| Yes ☐ | | No ☐ | | | If yes, please give details: | | | | | |
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| To protect your health at work, indicate in confidence to Workplace Health & Wellbeing if you are pregnant or breastfeeding | | | | | | | | | | |
| Yes ☐ | | No ☐ | | | Not applicable ☐ | | | | | |
| Do you have problems with vision or colour blindness? | | | | | | | | | | |
| Yes ☐ | | No ☐ | | |  | | | | | |
| Is this vision corrected with glasses or contact lenses? | | | | | | | | | | |
| Yes ☐ | | No ☐ | | |  | | | | | |
| Do you smoke? | | | | | | | | | | |
| Yes ☐ | | No ☐ | | |  | | | | | |
| Do you have any physical limitations which may affect your work or require job modification? | | | | | | | | | | |
| Yes ☐ | | No ☐ | | | If yes, please give details: | | | | | |
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| Do you have any allergies (to medicines or other substances including latex)? | | | | | | | | | | |
| Yes ☐ | | No ☐ | | | If yes, please give details: | | | | | |
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| During the past 2 years, on how many occasions have you taken sick leave from your workplace or training/college? | | | | | | | | | | |
|  | | No. of occasions | | |  | | | | | |
| Approximately how many days in total does this amount to? | | | | | | | | | | |
|  | | Total days | | |  | | | | | |
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| **Covid-19 Screening Questions**  What is your ethnicity? What is your weight? | | |  |  |
| What is your height? | What is your BMI? |  | | |

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| **SECTION D: Declaration** | | | | | | |
| Have you completed this Health Declaration form previously within the last six months? | | | | | | |
| Yes ☐ | | No ☐ |  | | | |
| I declare that the information I have given is correct to the best of my knowledge. I understand that I may be contacted by a member of the Workplace Health & Wellbeing Team to discuss information or the requirement of a clinical assessment. I understand that this offer of appointment or continued employment may be affected if I have intentionally left out any details or answered untruthfully.   I understand that a outcome certificate will be sent from Workplace Health & Wellbeing to the recruiting officer based on the above information provided. I understand that no confidential or personal health information will be released without my consent. | | | | | | |
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|  | | | | | | |
| Signed |  | | | Dated |  |  |
| ***PLEASE NOTE*** *–*  *This Pre-Placement Form will comprise part of your Occupational Health record once submitted. If you do not take up the post your completed form will be destroyed within 12 months.*  *All Occupational Health records are held in accordance with the Data Protection Regulation (GDPR) and Access to Medical Reports Act (1988). Electronic Occupational Health records are stored on a secure server which can only be accessed by the Occupational Health team using log in / passwords. Paper records are stored securely in locked cabinets and only the Occupational Health team have access to the keys. Access to the office is restricted to Occupational Health or authorised staff only. The office is locked during out of office hours so no one can access any information.*  *If you wish to view or receive a copy of your Occupational Health records held by Workplace Health & Wellbeing, we require a formal request and we will respond to your request within one month.* | | | | | | |
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| **Please return this form by email to –** [**workplace.health@nnuh.nhs.uk**](mailto:workplace.health@nnuh.nhs.uk)  **(we are unable to accept paper posted copies)** | | | | | | |