OCCUPATIONAL HEALTH QUESTIONNAIRE

Your answers to this questionnaire will be kept **CONFIDENTIAL** and will not be given to anyone else without your written permission. 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 place you at any risk in the workplace. We may recommend adjustments or assistance as a result of this assessment to enable you to do the job. Our aim is to promote and maintain the health of all people at work. Before health clearance is given for employment you may be contacted by your local Health Centre and you may need to be seen by an occupational health advisor or physician.
Please help us to help you by completing the questionnaire as fully as possible. Please complete this form in BLACK ink and block capitals

Title: Ms / Miss / Mrs / Mr / Dr / Professor:	Male Female
Surname/Family name:	First name:
Previous names (if applicable):	
Date of birth:	Proposed Job Title:
Home Address:	
Post code:	Are you new to working for the NHS? Yes No
Mobile:	Tel home:
Name of GP:	Tel No of GP:
Address of General Practitioner:	

Have you lived continuously in the UK for the last 5 years? Yes No

If no, please list all of the countries that you have lived in over the last 5 years

Please state your Immunisation status: **Date of vaccination:**

BCG :

Hepatitis B

[Please state if you do not wish to have the Hep B vaccination, and that a member of the recruitment team has explained fully and you are aware of the risks associated with not having the Hep B vaccine]
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MMR (Measles, Mumps, & Rubella)

Varicella (Chickenpox)

Tetanus

1. Do you have any illness/impairment/disability (physical or psychological) which may affect your work?
If **yes**, please give details below Yes No

2. Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?
Yes No

If **yes**, please give details below

3. Are you having, or waiting for treatment (including medication) or investigations at present? If your answer is yes, please provide further details of the condition, treatment and dates.
If **yes**, please give details below Yes No

4. Do you think you may need any adjustments or assistance to help you to do the job?
If **yes**, please give details below Yes No

5. Do you have any of the following:

(a) A cough which has lasted for more than 3 weeks? Yes No
(b) Unexplained weight loss? Yes No
(c) Unexplained fever? Yes No
(d) Diabetes Yes No
(e) Heart problems Yes No
Have you had tuberculosis (TB) or been in recent contact with open TB? Yes No
If **yes**, please give details below

HEALTHCARE WORKERS INVOLVED IN PATIENT CARE / PATIENT CONTACT

Have you ever had chickenpox?	Yes	No
Can you provide documented evidence of immunity to measles and rubella?	Yes	No
Have you ever had or tested **POSITIVE** for Hepatitis B?	Yes	No
Have you ever had or tested **POSITIVE** for Hepatitis C?	Yes	No

IF YOU HAVE PREVIOUS BLOOD RESULTS AND / OR DOCUMENTED EVIDENCE OF RELEVANT VACCINATIONS PLEASE SUPPLY A COPY WHEN YOU SUBMIT THIS FORM.

DECLARATION

I declare that the answers to the above questions are true and complete to the best of my knowledge and belief. I give permission for the employer to communicate with my own general practitioner, or any other health professional, if further information is required and for that GP or healthcare professional to give details of my clinical condition or other relevant information to TrustLink Care services Ltd.

I understand that I shall be contacted to obtain my fully informed consent **before** any report is requested and that under the Access to Medical Reports Act, 1988:

- I have the right to see the report before it is sent.
- I am entitled to ask the doctor to amend or modify information which I consider is inaccurate.
- I have 21 days from notification to seek access to the report.

Please provide any additional information in the space below

Signed ..... Date .....