Confidential Work Health Assessment

NHS
West Suffolk
NHS Foundation Trust

Dear Doctors,

Please find attached Occupational Health Declaration Form for completion and return to us as soon as possible.

Many thanks

Medical Staffing
West Suffolk Hospital

For Doctors currently employed by Addenbrookes only

The West Suffolk Hospital Occupational Health Department is part of 'Cambridge Health at Work' and therefore OH information is shared between the West Suffolk Hospital and Addenbrookes.

We require your signed declaration to allow West Suffolk Occupational Health to access your Occupational Health details. **You *will not* be required to complete the full OH Declaration form below.**

Name:

Mobile:

Date of Birth:

I confirm that I am happy for West Suffolk Hospital NHS Foundation Trust Occupational Health Department to request my full Occupational Health Records from Addenbrookes Hospital.

Signature:

Date:

Please return this declaration to Medical Staffing along with your starting documentation.

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Recruiting Officer to complete:

Proposed Job Title:

Ward/Department:

Full Time ☐ Part Time ☐

If Part Time, please state hours of work

Recruiting Officer: Medical Staffing

Job Reference: N/A

Permanent ☐ Temporary ☐

Proposed Start Date:

Please indicate which of the following hazards the named applicant is likely to be exposed to:

	Frequently	Occasionally	N/A		Frequently	Occasionally	N/A
Blood/Body Fluids	☐	☐	☐	Visual Display Units	☐	☐	☐
Chemical/Sensitisers	☐	☐	☐	Night Work	☐	☐	☐
Driving	☐	☐	☐	Repetitive Movements	☐	☐	☐
Manual Handling	☐	☐	☐	Powered Hand Tools	☐	☐	☐
Noise	☐	☐	☐	Working at Heights	☐	☐	☐

Applicant to complete the following sections:

The offer of employment is conditional upon health clearance which requires you to complete this form and return it to: **Occupational Health Department, West Suffolk Hospital, Hardwick Lane, Bury St Edmunds, Suffolk, IP33 2QZ.** If you have any difficulties please contact the department on 01284 713424 for advice.

Your answers to this questionnaire will be **CONFIDENTIAL** to the Occupational Health 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 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 asked to contact the Occupational Health Service and may need to be seen by an Occupational Health Nurse Advisor or Physician.

Title: ☐ Ms ☐ Miss ☐ Mrs ☐ Mr ☐ Dr ☐ Professor ☐ Other(Please Specify)

Surname/Family Name: Male ☐ Female ☐

Previous Name (if applicable): First Name:

National Insurance No: Date of Birth:

Home Address: Post Code:

Telephone Number (home): Mobile:

Name and Address of GP:

Telephone

Have you ever worked at the WSH? ☐ Yes ☐ No Are you new to the NHS? ☐ Yes ☐ No

Is this your first post since Professional Qualification? ☐ Yes ☐ No

As a requirement of the Nice Guidelines for the Clinical Diagnosis and Management of Tuberculosis and measures for its prevention and control, please answer the following questions:

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

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

Have you had a BCG vaccination in relation to Tuberculosis? ☐ Yes ☐ No

Approximate date of vaccination:

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

Have you had Tuberculosis (TB) or been in recent contact with open TB?If ☐ Yes ☐ No

Yes, please give details:

Medical Information

Height: Weight:

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:

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:

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:

Are you taking any regular prescribed medication? ☐ Yes ☐ No

If Yes, please give details:

Are you having or waiting for treatment or investigations at present? ☐ Yes ☐ No

If Yes, please give details:

How many days have you taken off from work or training/education due to illness in the last two years?

Are you or 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:

Musculoskeletal problems (such as back pain, arthritis, pains in upper limbs, lower limbs, neck, shoulder)? ☐ Yes ☐ No

If Yes, please give details:

Skin problems (including eczema, dermatitis or associated allergies eg latex)? ☐ Yes ☐ No

If Yes, please give details:

Immunisations (information may be available from your GP)

TB

BCG Immunisation Date

Scar present ☐ Yes ☐ No

Last Heaf/Mantoux Date

Heaf Grade

Mantoux Result mm

If previously had BCG scar check from Occupational Health Professional, please include documentary evidence.

Hepatitis B

Full course completed Date

Last Booster Date

Last Blood Test Date — Result

Surface Antigen Blood Test Date — Result

Hepatitis C

Blood Test Date — Result

HIV

Blood Test Date — Result

MMR

Immunisation Dose 1 Date — Dose 2 Date

Please include documentary evidence of vaccination dates

Rubella

Immunisation Date

Blood Test Date — Result

Measles

Immunisation Date — Dose 2 Date

Blood Test Date — Result

Chicken Pox

Immunisation Date — Dose 2 Date

Blood Test Date — Result

Polio

Immunisation Date — Last Booster Date

Tetanus

Immunisation Date — Last Booster Date

Diphtheria

Immunisation Date — Last Booster Date

Typhoid

Immunisation Date — Last Booster Date

Only Healthcare Workers involved in patient care/patient contact/body fluid sample handling complete this section (including laboratory workers)

Exposure Prone Procedures (EPP) are those procedures where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissue (eg, 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.

EPP staff 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.

All EPP staff **MUST** provide documentary evidence of Hepatitis B antibody and antigen status. **Documentary evidence of Hepatitis C and HIV status is also required for staff undertaking EPP's for the first time.** This must be an Identified Validated Sample (IVS). Health clearance for EPP work cannot be given until all these results have been received and processed by the Occupational Health Service. **If you have previous blood results and/or documented evidence of relevant vaccinations please supply a copy when you submit this form.**

If results are not available further tests will be carried out and health clearance for EPP work will be delayed until these results are processed. You will be asked to show formal photographic ID, ie valid driver's licence, passport or West Suffolk Hospital ID for this procedure. This is to comply with the Department of Health's standard for Identified Validated Samples (IVS).

Will you be performing Exposure Prone Procedures (EPP)? ☐ Yes ☐ No

Declaration

Before signing this Declaration, please ensure you have answered all the questions as instructed, providing further details as required. Please ensure the consent form is also signed and fully completed.

1. I hereby agree to inform the Occupational Health Service of any changes in my health which may affect my ability to work.

2. I understand my responsibility to notify the Occupational Health Service if I think I am carrying a serious communicable condition such as Hepatitis B/Hepatitis C/HIV or TB.

3. I acknowledge that my personal details will be stored both electronically and manually by the Occupational Health Service in accordance with the Data Protection Act 1998. This information will be retained during your period of employment and for an additional 40 years to comply with the Control of Substances Hazardous to Health (amended) Regulations 2004.

4. If I have any concerns about how this information is handled I will contact the Occupational Health Service.

5. I declare that the information provided by me in this entire form is true and complete to the best of my knowledge. I understand that any deliberate omission, falsification or misrepresentation in this record may result in disciplinary action by my employer.

Signature _____ Date _____

For Occupational Health Use Only

Reason for delay to health clearance	Date	Comment
☐ For confirmation of immunity status or pathology results (EPP)		
☐ Further information on health required		
☐ Appointment for OHNA offered		
☐ Appointment for OHP offered		
☐ Other		

Outcome ☐ Fit ☐ Fit with restrictions ☐ Unfit ☐ Fit for EPP ☐ Fit for Bank Work Only

Signature (OHNA/OHP): _____ **Date:** _____

Name (please print): _____