

**THIS INFORMATION IS CONFIDENTIAL TO WORKING WELL**

<b>Health Declaration for office based staff in Industry</b>	<b>Issue 1: NOV 2017 WWF- 002I</b>
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**EMPLOYMENT DETAILS** *Please complete in block capitals or type*

Job Title			
Organisation			
Department			
Hours of work	Full time <input type="checkbox"/>	Part-time <input type="checkbox"/>	Temporary/Fixed term <input type="checkbox"/> Months/Years
Start Date			

**APPOINTING MANAGERS DETAILS**

Name and Role	
Telephone Number	
Secure Work E-Mail	

**MANAGER TO HIGHLIGHT TASKS OR EXPOSURES WITHIN JOB**

Significant Manual Handling <input type="checkbox"/>	Respiratory Sensitisers/irritants <input type="checkbox"/>
Night Working 23:00-06:00 <input type="checkbox"/>	Vibrating Tools <input type="checkbox"/>
Food Handling <input type="checkbox"/>	Skin Sensitisers/irritants <input type="checkbox"/>
Lone Working <input type="checkbox"/>	Other (please state)

**PERSONAL DETAILS – TO BE COMPLETED BY CANDIDATE - *Please complete in block capitals or type***

Surname													
Forename													
Title			Date of Birth										
Gender													
Maiden/previous name													
Personal email													
Home phone number													
Mobile phone number													
Home Address													
Postcode													

Your appointment to your new role is subject to an assessment of your fitness to work. The purpose of this assessment is to:

- Identify any health problems or disabilities that may make the proposed job difficult or unsafe for you or others.
- To enable your employer to identify any adjustments to your work that may make life easier for you.

Please read the following three questions carefully. At the end there is a single **YES** or **NO** box to be ticked. To preserve medical confidentiality you are **not** required to identify any conditions/ illnesses you have or have had;

1. Do you have any health conditions or disabilities which might impair your ability to undertake effectively the duties of the position which you have been offered?
2. Do you have a health condition or disability which might affect your work and which might require special adjustments to your work or place of work?
3. Have you had in the last 6 months, a cough lasting more than 3 weeks, unexplained weight loss or unexplained fever?

To all of the questions above, I respond **NO**

**OR**

To one or more of the questions above, I respond **YES**

**Please sign below and return completed form to your appointing  
Manager/recruitment team**

If you tick **NO**, this form will be retained in your personal file. No further action is needed on your part. If you tick **YES**, your appointing manager will send this form to Working Well Occupational Health Service who will contact you to discuss your response. Usually issues can be resolved with a phone call but occasionally you may be required to attend Working Well for an appointment.

*In completing this form, you are certifying that to the best of your knowledge and belief the information given here is true and correct. Please note any deliberate material inaccuracy in this or any subsequent information given to Working Well may result in your placement being terminated.*

<b>Applicants Signature:</b>		<b>Date:</b>	
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**Privacy Notice**

No personal information held by us will be processed unless the requirements for fair and lawful processing can be met. Our Privacy Notice, which can be accessed at [Working Well](#) provides a summary of how we will ensure we meet these requirements.