

THIS INFORMATION IS CONFIDENTIAL TO WORKING WELL

Health Declaration for Industry Staff	Issue 1: DEC 2019 WWF - 005
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EMPLOYMENT DETAILS TO BE COMPLETED IN BLOCK CAPITALS BY APPOINTING MANAGER

New Employees Name			
New Employees Job Title			
Organisation			
Department			
Hours of work	Full Time <input type="checkbox"/>	Part-time <input type="checkbox"/>	Hours
Start Date			
Contract:	Full Time <input type="checkbox"/>	Fixed Term <input type="checkbox"/>	Months <input type="checkbox"/> Agency/Bank <input type="checkbox"/>

APPOINTING MANAGERS DETAILS

Name	
Telephone Number	
E-Mail address for e-fitness slip	

The Role will include the following tasks:

Visual Display Unit (VDU) Work <input type="checkbox"/>	Occupational Driving <input type="checkbox"/>	Fork Lift Truck Driving <input type="checkbox"/>
Significant Manual Handling <input type="checkbox"/>	00.00–05.00hrs Night Working <input type="checkbox"/>	Lone Working <input type="checkbox"/>
Other (please provide details) <input type="checkbox"/>		

The Role will include exposure to:

Respiratory Sensitisers / Irritants <input type="checkbox"/>	Significant/Repetitive Noise <input type="checkbox"/>	Dusts <input type="checkbox"/>
Hand Arm Vibration (HAVS) <input type="checkbox"/>	Skin Sensitisers/Irritants <input type="checkbox"/>	Chemicals <input type="checkbox"/>
Working at heights <input type="checkbox"/>	Confined Spaces <input type="checkbox"/>	
Other Hazards (please provide details) <input type="checkbox"/>		

PERSONAL DETAILS – TO BE COMPLETED IN BLOCK CAPITALS BY THE EMPLOYEE

Surname													
Forename													
Title				Date of birth									
Gender													
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**

Important information for the applicant

The contents of this questionnaire will remain confidential to your Working Well Occupational Health Service and will not be disclosed without your consent.

The purpose of new employee health screening is to ensure that:

- i. New staff do not have a health problem or disability that might impair their ability to carry out the tasks required in their new post
- ii. Any necessary adjustments can be made to enable new staff who do have a health problem or disability to carry out their job safely
- iii. The need for ongoing health surveillance can be identified

Applicants are advised that any false or misleading answers or failure to give pertinent information may render the individual liable to disciplinary action which may include dismissal.

OCCUPATIONAL HISTORY: Please list your previous jobs in chronological order starting with your present position (use a separate sheet if necessary):

	Organisation Name	Job Title	Dates (from-to)
1.			
2.			
3.			

Have you worked with, or been exposed to, any of the following: (tick as appropriate)

Computers <input type="checkbox"/>	Repetitive work <input type="checkbox"/>	Known respiratory sensitisers <input type="checkbox"/>
Noise (>80dBA) <input type="checkbox"/>	Vibration <input type="checkbox"/>	Known skin sensitisers <input type="checkbox"/>

Confined space <input type="checkbox"/>	Working at heights <input type="checkbox"/>	Fork Lift Truck Driving <input type="checkbox"/>
Occupational Driving <input type="checkbox"/>		
Other hazards (please give details) <input type="checkbox"/>		
Have you ever applied for compensation for any industrial injury/illness?		YES <input type="checkbox"/> NO <input type="checkbox"/>
If YES, please give details. Continue on a separate sheet of paper if necessary:		

YOUR MEDICAL HISTORY

Do you have any of the following: Please tick YES or NO

	Health Issue	Yes	No	Details/Dates if Yes
1	Heart disease (including High Blood Pressure)	<input type="checkbox"/>	<input type="checkbox"/>	
2	Lung disease including COPD and Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
3	Have you ever suffered from HAVS, Raynaud's Disease or Carpal Tunnel Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	
6	Recurrent Back, Joint or Muscle pain requiring more than over the counter medication	<input type="checkbox"/>	<input type="checkbox"/>	
7	Recurrent ear / nose / throat disease or hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	
8	Fits / blackouts / faints or loss or consciousness	<input type="checkbox"/>	<input type="checkbox"/>	
9	Diabetes: diet, tablet or insulin controlled	<input type="checkbox"/>	<input type="checkbox"/>	
10	Skin disease e.g. dermatitis, psoriasis etc.	<input type="checkbox"/>	<input type="checkbox"/>	
11	Eye disease / visual problems / colour blindness	<input type="checkbox"/>	<input type="checkbox"/>	
16	Are you at present taking medication?	<input type="checkbox"/>	<input type="checkbox"/>	
17	Are you waiting for any medical treatment or investigations, assessments etc?	<input type="checkbox"/>	<input type="checkbox"/>	
18	Have you lost time from work due to illness in the past two years?	<input type="checkbox"/>	<input type="checkbox"/>	
19	Have you ever left a post on grounds of ill-health?	<input type="checkbox"/>	<input type="checkbox"/>	

DECLARATION AND CONSENT: TO BE COMPLETED BY THE EMPLOYEE

I certify that the information I have given is true to the best of my knowledge and I understand that any deliberate material inaccuracy may result in the termination of my contract.

I agree to notify my employer of any change in my health which may affect my ability to undertake my job safely either for myself or others.

I understand that an Occupational Health record will be created and held confidentially by Working Well in accordance with the provisions of the General Data Protection Act 2018.

If Working Well holds previous occupational health records for me relating to former employment, I agree to Working Well accessing these records.

I understand that if any adjustments are necessary as a result of this assessment, Working Well will discuss these with me before making them to my employer.

Signed		Date	
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PLEASE RETURN YOUR COMPLETED FORM TO:

Working Well Occupational Health
Rikenel
Montpellier
Gloucester
GL1 1LY

Email: workingwell@ghc.nhs.uk

Sending documents by Email is the preferred, greener, option

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.