



The Bishop of Winchester Academy

Occupational Health Pre-Employment Questionnaire

Confidential

The information supplied on this form will be held in accordance with the principles of the Data Protection Act 1998. This information will be processed and retained by the Occupational Health Team.

Please complete this form and return it with your application, in an envelope marked 'Confidential' with your name and details of the post applied for. The envelope will be sent for processing should your application be successful.

Section 1 - Your Details

Post applied for:		Site/Department/School:	
Intended start date:		Name of recruiting manager:	
Surname:		Forename(s):	

Section 2 - Occupational History

Please list all the jobs you have held in the past 5 years and approximate dates (continue on a separate sheet if necessary)

Previous jobs	Dates from/to

Have you ever left a job (in whatever circumstances) by reason, in whole or part, related to your health? Yes No

Please give details of any sickness absence you have had in the last 2 years

Date of absence (Month/Year)	Reason for Absence	No. of days sick

Section 3 - Medical History (if ticked 'Yes' - please use space provided on page 2)

Please complete all the questions below:

- Are you currently waiting for any medical investigations and/or admission to hospital? (including physiotherapy, chiropractor, osteopathy) Yes No
- Are you currently having any treatment or taking any medicines? Yes No
- Have you consulted a Doctor, or other medical or related practitioner within the last 2 years, for an illness/disability/injury? Yes No
- Do you have any eye sight problems not corrected with glasses? Yes No

Medical History

Please complete all the questions below:

5. Do you have any hearing problems not corrected by a hearing aid? Yes No
6. Do you have any problems standing, climbing stairs, working at heights, lifting or carrying? Yes No

Have you, either now or in the past, had any of the following:- Yes No

- | | | |
|--|--------------------------|--------------------------|
| 7. Heart trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Chest trouble e.g. bronchitis, asthma, TB, etc | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Stomach/Bowel trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Hernia or Rupture | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. ME/Post Viral Fatigue Syndrome | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Back/Neck problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Joint problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Fits/Faints/Blackouts/Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Skin problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Any allergies e.g. hay fever, eczema etc | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Depression/Anxiety/Severe Stress Reaction/other Mental Health problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have any disorder or other condition, not mentioned above? | <input type="checkbox"/> | <input type="checkbox"/> |

If you have ticked YES to any of the questions 1-19 above please give dates and details here:

Section 4 - Immunisation Status.

Only to be completed by individuals who are applying to be Care Assistants or Registered Nurses in residential units.

Have you ever been immunised against the following?

Tetanus	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Year:	<input type="text"/>	
Polio	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Year:	<input type="text"/>	
BCG (Tuberculosis)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Year:	<input type="text"/>	
Diphtheria	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Year:	<input type="text"/>	
Hepatitis B	1st Injection	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Year:	<input type="text"/>
	2nd Injection	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Year:	<input type="text"/>
	3rd Injection	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Year:	<input type="text"/>
Has your blood test confirmed immunity to Hepatitis B		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		

Section 5 - Food Handlers.

Only to be completed by applicants whose post will require preparation and/or serving of food.

Are you currently or have you suffered from any of the following illness in the last 3 months

Diarrhoea	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date:	<input type="text"/>
Food Poisoning	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date:	<input type="text"/>
Skin Trouble	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date:	<input type="text"/>
Ear/Eye Infection	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date:	<input type="text"/>
Sore Throat	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date:	<input type="text"/>
Sinusitis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date:	<input type="text"/>
Chest trouble (e.g. TB, bronchitis etc)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date:	<input type="text"/>
Persistent Cough	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date:	<input type="text"/>
Vomiting (as the result of known or suspected food poisoning)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Date:	<input type="text"/>

I certify that, to the best of my knowledge, the information given hereafter is true. I agree that any deliberate omission, falsification or misrepresentation in the form may be grounds for rejecting this application or subsequent dismissal by the employer.

I acknowledge that my personal details will be stored and handled by Dorset HealthCare University Trust Occupational Health Service in accordance with the Data Protection Act 1988.

Signature:

Date:

Please ensure you have completed all the relevant sections and the consent form overleaf.

For Occupational Health Use

Fit..... Fit with restrictions.....Further assessment needed.....

Access to Medical Information - Consent Form (Reference - Access to Medical Reports Act 1988)

To be completed by all applicants

Surname:

Forenames(s):

Full Address:

Post code:

Tel No.(inc code)

Mobile No.

E-mail:

Date of Birth

GP Details

Surname

Forenames(s):

Full Address:

Post code:

Tel NO.(inc code)

The Occupational Health Advisor may request medical information from your doctor. The Access to Medical Reports Act 1988 gives you the right to check the accuracy of such a report before it is sent to us.

Your rights under the Access to Medical Reports Act 1988 are summarised below. Please read them carefully before you sign your form.

You are entitled to :

1. Withhold your consent for an application to be made to your doctor.
2. See the medical reports before it is supplied to Dorset Health Care Occupational Health Advisor, (you have 21 days from the date the report is requested to view it before it is sent). It is your responsibility to make the necessary arrangements with your doctor.
3. Ask your doctor to amend any part of the report which you consider to be inaccurate or misleading. If your doctor declines to amend the report, you may attach a written statement giving your views or you may withdraw your consent to the report being supplied to Dorset Health Care Occupational Health Advisor.

In exceptional circumstances your doctor may consider that your health may be seriously jeopardised and may withhold part of the report from you.

Declaration

1. I have read my statutory rights under the Access to Medical Reports Act 1988 (shown above) and hereby give my consent to Dorset Health Care Occupational Health Advisor to apply for a medical report from my doctor who has been responsible for my physical or mental health care.
2. I do understand that this consent form will be copied to that doctor and shall have the validity of the original
3. I do/do not* wish to see my doctor's medical report before it is sent to the Dorset Health Care Occupational Health Advisor. (* please delete as appropriate)

Signature

Date:

(If you do not wish to see your GP report before it is sent to our Occupational Health Advisor, you are still entitled to view it at your GP surgery for six months after the date it was requested)

Occupational Health Advisor = Occupational Health Physician or Occupational Health Nurse