#### STRICTLY PRIVATE AND CONFIDENTIAL

**PRE-EMPLOYMENT HEALTH DECLARATION**

**Section A – Must be completed by Appointing Officer before questionnaire is given to applicant.**

|  |  |
| --- | --- |
| Proposed position as per Job Description title (Full title, no abbreviations): | |
| Directorate: | Service/School: |
| Hours of work (contractual hours): | Newly Qualified Teacher/Social Worker: Yes  No |
| Name of Appointing Officer: | HR Contact: |
| To ascertain Health Surveillance requirements please indicate if this work involves any of the below Yes  No  If Yes, please indicate which  Exposure to Noise  Exposure to chemicals/Dust/Fumes  Exposure to Vibration | |
| Does the work also involve any of the tasks below? Yes  No  If Yes, please indicate which:  Heavy Manual Handling  Work with Moving Machinery  Work at Heights  Working in Isolation  Display Screen Equipment Use  Night Work  Food handling  Driving Large Vehicles or Passenger Carry Vehicles (minibuses)  CALM/Restraint ☐ NAPPI/Restraint ☐ | |

# Section B - All further sections to be completed by the Applicant

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 an Occupational Health Advisor. An appointment with the Occupational Health Physician may also be necessary. Please help us to help you by completing the questionnaire as fully as possible.

**Personal Details:**

|  |  |  |
| --- | --- | --- |
| Surname: | | Title: |
| Forename(s): | | Date of Birth: |
| Home Telephone: | | Mobile: |
| Home Address: | | |
| Postcode: | Email: | |
| Have you worked for Northumberland County Council in the last 5 years? Yes  No | | |

**Sickness Absence Record:**

|  |  |  |
| --- | --- | --- |
| Please detail the number of days you have been absent from work (or school) in the last two years. Outline the reasons for absence, please state if these absent dates where due to a disability. | | |
| How many days were you absent? | When was this? | Reason for absence: |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| **Have you any health problems which affect your ability to:** | **Answer** |
| Drive | Yes  No |
| Sit for long periods | Yes  No |
| Stand | Yes  No |
| Walk | Yes  No |
| Climb Stairs | Yes  No |
| Lift | Yes  No |
| Use Hands | Yes  No |
| Work at heights/ladders/staging | Yes  No |
| Work in a noisy environment | Yes  No |
| Work with vibratory tools | Yes  No |
| **If you have answered ‘Yes’ to any of the above, please give details:** | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Current Medical Treatment** | **Answer** | **Further details:** | |
| Are you attending a GP for treatment, attending a hospital for treatment or currently awaiting an appointment for treatment? | Yes  No |  | |
| Are you receiving any prescribed medications (tablets, inhalers, creams, injections, etc.) at the moment? | Yes  No |  | |
| Past Medical History | **Answer** | **Further details:** | |
| Have you had to leave a job due to ill health or been medically retired? | Yes  No |  | |
| Do you have, or have you ever had, any health condition which may have been caused, or made worse, by work? | Yes  No |  | |
| Do you consider yourself to have a disability? If yes please specify the disability. | Yes  No |  | |
| Have you ever been declined ill health benefits or told you would not be eligible for them? | Yes  No |  | |
| Have you ever had any difficulties at work or in education as a result of a medical condition or learning difficulty (including autism, dyslexia, dyspraxia and Attention Deficit Hyperactivity Disorder – ADHD) | Yes  No |  | |
| Equality Act 2010 A disability is defined by the Equality Act 2010 as “A physical or mental impairment which has a substantial and long-term adverse effect on a person’s ability to carry out normal day-to-day activities. | | | |
| Do you have a disability that may affect your ability to undertake the role which you have been offered or that requires special arrangements to be made to allow you to undertake the role? | | | Yes  No |
| If yes, please tell us what adjustments, equipment or facilities you would require to enable you to perform the role: | | | |

|  |  |  |
| --- | --- | --- |
| **Have you ever had any of the following?** | **Answer** | **If yes, provide details** |
| Allergies (including hayfever) | Yes  No |  |
| Frequent headaches or migraine's | Yes  No |  |
| Low or high blood pressure | Yes  No |  |
| Any other blood condition or disorder | Yes  No |  |
| Skin disorders such as eczema, psoriasis or skin rashes | Yes  No |  |
| Visual disturbances or defects such as blurred vision, colour blindness, scotoma, reduced visual field or blindness | Yes  No |  |
| Hearing or ear issues | Yes  No |  |
| Balance problems, vertigo, unexplained dizzy spells | Yes  No |  |
| Fits, blackouts, epilepsy, fainting or unexplained periods of unconsciousness | Yes  No |  |
| Nervous system diseases such as strokes, neuritis or multiple sclerosis | Yes  No |  |
| Lung issues such as pneumonia, emphysema, asthma or bronchitis | Yes  No |  |
| Malignancies or cancers | Yes  No |  |
| Unexplained breathlessness, chest pain, angina or heart disease | Yes  No |  |
| Bladder or Kidney conditions | Yes  No |  |
| Liver conditions such as jaundice or hepatitis | Yes  No |  |
| Metabolic conditions such as thyroid/adrenal gland disease or diabetes | Yes  No |  |
| Rheumatism, Arthritis, gout or similar | Yes  No |  |
| Infectious diseases | Yes  No |  |
| Stress related problems, anxiety problems, depression or mental breakdowns | Yes  No |  |
| Misuse of substances such as drugs, steroids or alcohol | Yes  No |  |
| Any surgical procedures or operations | Yes  No |  |
| Any other medical conditions, illness or disease | Yes  No |  |
| Do you have, or have you ever had, any kind of back, joint/limb or muscle problem? | Yes  No |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Occupational Health Declaration/Consent Form** | | | |
| I declare that all the answers given in the above Pre-Employment Health Declaration are complete, true and I have not omitted any information, or mislead the County Council. I understand this would be sufficient grounds for serious action to be taken against me, including dismissal.  I consent to the processing of my personal data included in this document for the purposes of the General Data Protection Regulations 2018 and understand that the data is being collected   * to help identify employees who need further health assessment or advice. * to enable the Occupational Health Advisor to give an opinion on fitness for a new job and to advise on any reasonable adjustments that may be required. * to be a record of health status at the start of employment   Following my conditional offer of employment, I consent to:   * being medically examined/assessed by an Occupational Health Physician if required. * my proposed employer being notified about my medical fitness and any adjustments that may be required to enable me to take up the duties required by the post. This will include information about all absences from work or education in the last two years.   I understand that I cannot be offered the post without a report/certificate from Occupational Health. | | | |
| Signature: |  | Date: |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **For office use only:** | | | | | | | | |
| **Incomplete** | |  | | | **FIT:** | Yes  No | | |
| **Appointment** | |  | | | **Fit with restrictions:** | | |  |
| **Adjustments Required:** | | | |  | | | | |
| **GP Report** |  | | | | **UNFIT:** | |  | |
| **OHA Signature:** | | |  | | | | | |
| **Date:** | | |  | | | | | |