WORK HEALTH ASSESSMENT FORM

Guidance for Completing the Work Health Assessment

The purpose of the questionnaire is to determine whether you have health problems that could affect your ability to undertake the duties of the post you have been offered or place you at risk in the workplace. It may be that adjustments or support is recommended 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.

Your answers to this questionnaire will be confidential to Occupational Health and will not be given to anyone else without your written permission. We do use anonymised information for audit purposes but will not reveal confidential information in any audit report. Specific guidance about the declaration form is given below:

Please complete all relevant sections, otherwise the form may be returned for completion therefore delaying the process;

Personal Details
All sections must be completed. Please only provide contact details that you are happy for us to use as part of your work health assessment and for any subsequent communication. Please ensure Name, Date of Birth and NHS Number is completed on each page

Consent
If you already have Occupational Health records held in the Pennine Acute Hospital NHS Trust Occupational Health Department which were for a position with a different Trust/ organisation then we need your consent to access them. It will prevent you from having to attend for further appointments if consent is given to use your existing notes. If you are in agreement with your Occupational Health records being copied and used for assessment, please answer yes and sign.

PART A – Health Assessment Questions – To allow for support or adjustments to the workplace
These questions have been designed to allow an assessment of your health and well-being in relation to the proposed job. If you have a illness/ impairment or disability that may affect your work and you need adjustments or any support you should complete this section. In particular, health problems that may affect work tasks or be affected by work patterns such as night work or working environments should be disclosed.

PART B Immunisations and Blood Tests – Immunisation Assessment Section
If you will be involved in direct patient care (as defined below for health care workers) or body fluid sample handling, please ensure that you provide details of any previous immunisations and blood tests.

*Definition of Healthcare Workers
The Association of National Health Occupational Physicians (ANHOPS) guidance on Immunisation of healthcare workers defines three categories of healthcare workers:

- Clinical staff who have regular clinical contact with patients. This includes staff such as doctors, dentists and nurses, paramedical professionals such as occupational therapists, physiotherapists, radiographers, ambulance workers, and students in these disciplines;
- Laboratory and other staff (including mortuary staff) who have direct contact with potentially infectious clinical specimens and may additionally be exposed to pathogens in the laboratory. (This includes other staff in contact with blood and body fluids including disposal, cleaning or laundry)
- Ancillary staff who may have social/clinical contact with patients, of a prolonged or close nature. This group includes ward clerks, volunteers and porters.

If you require immunisations or blood tests an appointment will be sent to you to attend the Occupational Health Department.
Deanery Trainee Occupational Health Employment Clearance Procedure

Please complete all areas of the form including all the required information so that you clearance for work can be completed without delay.

Complete the form in full and provide evidence of all immunisation details or it will delay your clearance for work.

If you are not cleared following this process you will not be able to work and…

…you will not be paid.

If you require tests and/or immunisations this must unequivocally be carried out on a Mediscreen site.

Foreign Travel and exposure to Tuberculosis can seriously delay clearance. Please complete all areas of the TB assessment. If you answer yes and require investigation following have travel to a high risk country:

You must be in the UK for 8 weeks before the test can be carried out.

The test will not be carried out sooner than 8 weeks.

If there is a delay you will not be cleared to work.

If you still have any questions or would like further information regarding the procedure, please contact the occupational health department using the details below or on the following email address; OccupationalHealth.Deanerytrainees@pat.nhs.uk
### Personal Details – To be completed by prospective employee

This questionnaire forms part of the appointments procedure and will also be part of your Occupational Health record. If you have any difficulties completing this form, please contact the Occupational Health Department for advice, our contact details are listed on the last page.

Please complete this section in BLOCK letters.

<table>
<thead>
<tr>
<th>SURNAME</th>
<th>Title</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>FORENAMES</td>
<td>FORMER NAME(S)</td>
<td>MALE / FEMALE</td>
</tr>
<tr>
<td>ADDRESS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POSTCODE</td>
<td>HOME TELEPHONE NO:</td>
<td>MOBILE</td>
</tr>
<tr>
<td>NHS NUMBER</td>
<td>EMAIL</td>
<td></td>
</tr>
<tr>
<td>GENERAL PRACTITIONER (Name &amp; Address)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are you new to working for the NHS

Yes / No

Have you ever worked or trained here

Yes / No

If yes please consider completing the consent to use existing notes

Please provide details of your previous position(s) most recent first

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Organisation</th>
<th>Specialty/Type of Work</th>
<th>Date from DD/MM/YY</th>
<th>Date left/leaving DD/MM/YY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Details of Position**

**POST TITLE**  
CT/ST

**ORGANISATION/TRUST**  
Deanery

**DIVISION/DIRECTORATE**  
HR

**AREA**  
Deanery

**FULL / PARTTIME (Hours)**  
N/A

**NEW TO ORGANISATION / INTERNAL TFR**  
(Delete as appropriate)

**CONTACT MANAGER**  
Lisa Moorhouse

**MANAGERS TEL NO:**  
4 5829

**EMAIL OF APPOINTING MANAGER**  
lisa.moorhouse@pat.nhs.uk

**FOLLOWING RISK ASSESSMENT OF THE ABOVE POSITION PLEASE INDICATE IF ANY HEALTH SURVEILLANCE IS REQUIRED?**  
i.e. Exposure to Noise/Respiratory Sensitisers  
N/A
Consent for Occupational Health Records to be copied

If you consent to your Occupational Health records being copied and used to assist in the assessment for your new position please complete the below.

Previous / Present Post Title ____________________________________________________

Previous Trust / Company’s Name _______________________________________________________________________

I give consent for my Occupational Health records to be copied, including vaccinations and blood results to be used for assessment

__________________________________________________ signature

____________________________ Date ______________________________

PART A – Health Assessment Section

Please complete this section

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Do you have any illness/ impairment / disability? (physical or psychological) which may affect your work? If yes please give details with dates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Have you ever had any illness / impairment / disability which may have been caused or made worse by your work? If yes please give details with dates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Are you having, or waiting for treatment (including medication) or investigation at present? If yes please provide further details of the condition, treatment and dates.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Do you think you may need any adjustments or assistance to help you to do the job? If yes please give details</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PART B – Immunisation Assessment Section

TO BE COMPLETED BY HEALTH CARE WORKERS INVOLVED IN PATIENT CARE / CONTACT / BODY FLUID SAMPLE HANDLING (INCLUDING LABORATORY WORKERS)

Immunisation and Blood Tests -- Please provide the following details attaching documentary evidence where indicated (*) if information provided is incomplete you will be required to attend an appointment at Occupational Health.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>DATES</th>
<th>Results attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B vaccination</td>
<td>*</td>
<td></td>
<td>Not required</td>
</tr>
<tr>
<td>Hepatitis B 5 year booster</td>
<td>*</td>
<td></td>
<td>Not required</td>
</tr>
<tr>
<td>Hepatitis B (showing titre levels &gt;10iu/ml or indicate if non-responder to vaccine)</td>
<td></td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Measles Vaccination</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps Vaccination</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella Vaccination (German Measles)</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR Vaccination</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles antibodies</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps antibodies</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella antibodies (German Measles)</td>
<td>*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Have you ever suffered from Chicken Pox / Shingles? Born or raised in tropical or subtropical climates? Varicella antibodies tested? Varicella Vaccination received? | | | *
| Tested positive for infection for HIV, Hepatitis B or Hepatitis C? | | | *
| Have you had Tuberculosis (TB) or in the last 12 months, had any unexplained weight loss, night sweats, cough lasting more than 3 weeks or coughing up blood? Has a family member or close friend ever been diagnosed as having TB? To your knowledge have you had any recent contact with TB? Have you lived, travelled or worked abroad for more than 4 weeks in the last 5 years? If yes please answer the following questions in full: Which country did you reside in/travel to? What were the dates of your residence/travel? What was the purpose of your travel? Where did you stay, i.e. hotel/ with family or friends/other? To the best of your knowledge did you have any prolonged TB contact? i.e. | | | |
a cumulative exposure period >8 hours within the same room as an infected case and/or ‘providing care on a dependent infected case resulting in contact with respiratory secretions

Since your return to the UK, have you developed any TB symptoms (as above, if so please indicate) or been screened for TB?

Mantoux or heaf test, chest x-ray Interferon Gamma Test
BCG (Tuberculosis Vaccination)

If yes, do you have evidence of a BCG scar? Yes / No
Do you have documented evidence of this? Yes / No

Will you be performing exposure prone procedures? (EPP) - definition below Yes / No
If yes, what date did you commence working in an EPP role within the NHS? ____________________________________________
Will you be working on a renal unit, if so you must provide documentary evidence of Hepatitis B status Yes / No

Exposure Prone Procedures (EPP) are those procedures where the worker’s gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (e.g. 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), Anesthetists, Dental Staff, Theatre Staff, Midwives, Podiatrists, A&E Doctors and Nurses.

EPP staff MUST provide documentary evidence of Hepatitis B status. Documentary evidence of Hepatitis C and HIV status is also required for staff undertaking EPPs for the first time. This must be an identified validated sample (IVS – taken in an occupational health department and lab /immunisation report stamped by that department). Health clearance for EPP work cannot be given until these results have been received and processed by Occupational Health.

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 you will be tested in the Occupational Health Department and health clearance for EPP work will be delayed until these results are processed. In compliance with Department of Health guidelines you will be asked to show government photographic ID i.e. valid driver’s license or passport for this procedure.

N.B. Health Care Workers who perform EPPs have a legal duty to inform Occupational Health if they suspect or know that they are carriers of HIV, Hepatitis B or Hepatitis C

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>DATE</th>
<th>RESULTS ATTACHED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Hepatitis B surface antibodies (from 1993) and antigen (from 2007)
Hepatitis C antibodies (from 2002)
HIV antibodies (from 2007)

Declaration
I declare that all the answers to the above questions and information are true to the best of my knowledge. I agree to comply with immunisations and screening requirements of the post and any failure to comply will result in my manager being informed and may result in restrictions on clinical practice.

Signed ______________________________________ Date ______________________

I understand that if any recommendations to my manager are necessary as a result of this Work Health Assessment, Occupational Health will discuss the recommendations with me before informing my manager.
*After discussion with Occupational Health I give consent for a report regarding the recommendations to be sent to my manager, without me having seen a written copy of the recommendations

Or

*I would like to see a written copy of any recommendations made by Occupational Health before it is sent to my manager

* Please delete one of the above statements before signing below

Signed _____________________________ Date _____________________________

Contact Details
Pennine Acute Hospitals NHS Trust
Mediscreen - Occupational Health Department
North Manchester General Hospital
Delaunay's Road
Manchester, M8 5RB

Tel 0161 720 2727 Fax 0161 720 2636 Email OccupationalHealth.Deanerytrainees@pat.nhs.uk