**PRE-EMPLOYMENT HEALTH QUESTIONNAIRE**

Dear candidate,

As part of the recruitment process, we need to assess that you are fit for the post you have applied for, and that the work activities you will be required to undertake will not pose an unreasonable risk to your health. This is part of our commitment to you, should you be appointed to the position for which you have applied.

You are required to complete the health questionnaire. Completed forms should be signed and returned directly to: Occupational Health Service by post to Derby City Council, Stores Road Depot 15 Stores Road, Derby, DE21 4BD or alternatively once completed and signed scanned to occupational.healthservice@derby.gov.uk. (We are unable to accept forms that are not signed).

This forms part of your employment checks therefore it is imperative that you complete and return as soon as possible in order to avoid any delays in your appointment.

Please note this form will be returned if it is not completed correctly which will delay your recruitment.

Regards,

The Occupational Health Team

***WHAT THIS QUESTIONNAIRE IS ABOUT?***

**Important:** Please read the following notes including the privacy notice attached then complete each section of this questionnaire. If you have any questions about this questionnaire, please contact Occupational Health Team on 01332 640543.

**Purpose of the questionnaire**: The purpose of the pre-employment screening is to ensure, as far as possible, that you are fit for the post you have applied for, and that the work activities you will be required to undertake will not pose an unreasonable risk to your health. We ask questions are asked about your past and present health and we will tell. Your (prospective) manager at Derby City Council whether you are fit to carry out the duties of the post offered, and suggest any support you may require to perform those duties effectively.

**Confidentiality**: All information provided by you in completing this questionnaire will be treated in the strictest confidence by the occupational health clinical team except when required/permitted by law. Please answer all the questions as fully and accurately so that your fitness for employment can be assessed objectively and promptly.

Confidentiality is fundamental to the work of all Occupational Health Staff. Occupational Health Professionals are bound by an ethical code of conduct in the same way that they would be in a General Practice or Hospital. All members of the Occupational Health Team understand their responsibility to protect sensitive and personal information and have given an undertaking that they will do so. We keep a record of the work that we do so that we can remain compliant with health and safety law, protect the health of employees.

**NOTE**. If there is ever a reason to release any confidential information then we will always obtain your written consent first. This is one of the reasons for providing you with the information in this statement. It also gives you the chance to sign the statement below to confirm that you have read and understood this information and that you consent to us keeping your occupational health records in the way we have described. You can request a copy of your Occupational Health Records at any time by submitting a formal request in writing to the Occupational Health Department. Please see privacy notice attached on next sheet under GDPR 2018 rules.

**PRIVACY NOTICE**

**Layer 1 Privacy Notice for the Occupational Health Service**

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| |  | | --- | | **How is your information used?**  We will use your information to enable us to provide the services you request from us. This will include to:   * set up and maintain confidential, secure medical records * monitor your health throughout your assessments with us * arrange further appointments with our Occupational Health Physician Provider where necessary and explicit consent given (Hobson’s Health) * obtain further medical evidence from your treating specialist or GP with your consent.   **Who has access to your information?**  Only authorised personnel in the Occupational Health Team and our resident Occupational Health Physician provided by Hobsons Health have access to your information.  Staff within the service means our Occupational Health Advisors, Service Manager and administrators. The reasons for are listed below…   * Our clinical staff need access to your information to be able to carry out the health assessments work that the referring manager have requested by referring into the service. * The service manager can access your information to audit the service. This is to ensure that corporate and local policies and procedures are followed and to fulfil risk assessment and risk management responsibilities under health and safety legislation. * The service manager and administrators can access your information in order to ensure the service operates efficiently and clinics are organised and prepared to the required standards. * Our administrators need access to certain medical information so that the service can respond to enquiries as they arrive and to report on service levels and effectiveness and ensure a clinical member of the team can respond within timescales.   On rare occasions if we believe someone is at serious risk of harm, we may have a duty of care to report this information to the police or safeguarding board.  In all other circumstances, we will only share any information with your explicit consent including when referral may be required to Hobson’s Health Physician.  We will not sell or rent your information to third parties. We will not share your information with third parties for marketing purposes.  *For further information about your personal information will be used, please visit www.derby.gov.uk where you can see a full copy of our privacy notice.*  **To be completed by the Applicant**  Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Sex Male / Female / Transgender Postcode\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Job Title applied for:  Directorate  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Tel \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Mobile **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |

**SECTION 1**

**Please read following statements below and tick A or B at the end of the five statements.**

* Do you need any special aids/adaptations to assist you at work, whether or not you have a disability?
* Do you have a medical condition or disability which may affect your ability to carry out your proposed work?
* Are you having, or waiting for, treatment or investigation of any kind at present?
* Have you ever left a previous employment through ill-health or a work related injury or condition?
* Do you have any back, neck or joint problems causing difficulty with standing, walking, bending, lifting, gripping or stair climbing?
* Are you taking any medication prescribed by your doctor or pharmacist on a regular basis whose side effects may affect you at work?

1. I would answer yes to one or more of the above
2. None of the above applies to me

Applicant’s signature Date

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**DECLARATION**

I declare that the information I have given on this form is true to the best of my knowledge and belief. I understand that a failure to provide information and/or a submission of inaccurate information relating to my health may result in breach of contract and disciplinary action being taken which may lead to termination of your employment.

I am willing to undergo a medical consultation if necessary.

**PLEASE ONLY COMPLETE SECTION 2 OF THE FORM IF YOU HAVE ANSWERED YES TO ONE OR MORE OF THE QUESTIONS STATED ABOVE**

**SECTION TWO**

Please answer all of the following questions. If you answer **YES** please give details on the following page.

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|  |  | **YES** | **NO** |
| **1** | Have you ever seen a doctor in the last year for any kind of health problem? |  |  |
| **2** | Are you having, or waiting for, any treatment or investigations of any kind at the moment? |  |  |
| **3** | Do you have or ever had a history of blackouts, fits, or epilepsy? |  |  |
| **4** | Do you have diabetes, thyroid, or gland problems? |  |  |
| **5** | Have you ever failed a medical or health screen or had any special conditions imposed for any employment. If yes please give details on the following page |  |  |
| **6** | Have you ever been retired on grounds of ill health from any employment? If yes please give details on the following page |  |  |
| **7** | Are you taking any medication (excluding contraception), injections, creams/ointments? If yes, please state type and dose and reason for taking |  |  |
| **8** | Have you ever had a mental health problem or psychiatric illness eg nerves, phobias, stress, anxiety, depression, eating disorders, anorexia or bulimia? |  |  |
| **9** | Have you ever deliberately harmed yourself in any way? |  |  |
| **10** | Do you take any drugs or prescribed medication that may cause impairment? |  |  |
| **11** | Do you have any skin problems or allergies including latex allergy (eg eczema, asthma or dermatitis) or an adverse reaction to any medication of substance? |  |  |
| **12** | Do you have any health condition or injury caused or made worse by work? |  |  |
| **13** | Do you have any other medical condition that may affect you ability to perform the proposed job? |  |  |
| **14** | Have you a sensory problem such as hearing or sight problems not corrected by adaptive aids such as hearing aids, glasses or contact lenses, and/or a speech or communication difficulty? |  |  |
| **15** | Do you have any musculo-skeletal conditions that affect you ability to perform work tasks (including recurrent back pain, or hand, arm or shoulder problem) ie back, neck or joint problems |  |  |
| **16** | Have you any difficulty with any of the following activities? |  |  |
|  | a) Standing |  |  |
|  | b) Walking |  |  |
|  | c) Sitting |  |  |
|  | d) Stair Climbing |  |  |
|  | e) Lifting |  |  |
|  | f) Driving |  |  |
|  | g) Kneeling, squatting, bending |  |  |
|  | h) Manual dexterity |  |  |
|  | i) Co-ordination |  |  |

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| --- | --- | --- | --- |
| **17** | Have you developed or suffered from heart attack, heart disease, angina or chest pain? |  |  |
| **18** | Have you developed or suffered from high blood pressure? |  |  |
| **19** | Do you suffer with any sleep disorders? |  |  |
| **20** | Have you developed or suffered from severe chest or lung condition, asthma or chronic obstructive airways disease? |  |  |
| **21** | Have you had any emergency operations or treatment ? |  |  |

**In this section please give details of the questions to which you have answered YES.**

|  |  |
| --- | --- |
| **Question number** | **Details** |
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Please continue on a separate sheet of paper if necessary.

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| **Equality Act 2010:** The Occupational Health Service operates and advises in accordance with this Act. (A physical or mental impairment is one which has a long-term adverse effect on a person's ability to carry out day-to-day activities including work). If you have a condition that may fall under the scope of this Act we may need to advise your prospective manager on suitable workplace adjustments.    **Do you consider yourself to have a condition that falls under the act?**  **YES / NO** |

Applicant’s signature Date

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**Below for Occupational Health use only**

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| 2. |
| 3. |
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| --- | --- | --- |
| **Occupational Health Advisor only** | **Yes** | **OHA Initials** |
| **A** |  |  |
| **B** |  |  |
| **C** |  |  |
| **D** |  |  |

Signed by DCC OHA …………………………… Date…………………………