

Occupational Health Declaration Form



Health Record (continued)		
Previous work related health issues		
Have you ever had a health condition that was made worse by work?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you been retired from a previous job because of ill health?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If you have answered yes to any of the above questions please provide details including dates:		
Disability		
Have you ever been registered or judged disabled?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have an impairment which might qualify under the Disability Discrimination Act 1995?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you left a previous position due to a disability?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If you have answered yes to any of the above questions please provide details including dates:		

Additional Information		
Have you previously worked in the National Health Service?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If you have answered yes to the above question please provide details including dates:		

Declaration	
I confirm that I have read this document fully and that all the information given to Medacs Doctors is correct to the best of my knowledge and belief. I am aware of the need to protect patients and myself and agree to notify Medacs Doctors if my circumstances alter.	
I understand that the information contained in this form is sensitive personal data within the meaning of the Data Protection Act 1998 and that in signing this form I am agreeing to Medacs Doctors processing my data as detailed in this form. I confirm that I consent to a copy of my fitness certificate declaring my fitness to work and containing information on my immunity status being sent to any client of Medacs Doctors to whom I may seek assignments from time to time.	
I have read and agree to adhere to Medacs Healthcare's Terms of Engagement.	
Name: _____	Signature: _____
D.O.B: _____	Date: _____

This Occupational Health screening is undertaken in order to limit the risk of your health being detrimentally affected by your work and to ensure you are fit to undertake the duties of the roles for which you have applied. This information is assessed by Medacs Healthcare's Occupational Health Department and only the staff working there will have access to this information.

The Occupational Health Department will provide your Placement Officer with a Certificate of Fitness which will confirm your fitness to undertake the duties required and will also contain details of your immunity status. Placement Officers may disclose this certificate to Clients for the purpose of finding you suitable assignments.

You may be contacted by the Occupational Health Department for further information or be asked to attend a medical examination. The Occupational Health Department will not communicate with any other health professional (such as a GP or any other Occupational Health Department) or disclose the information on this form without you providing separate written consent.

Information contained within this Occupational Health Declaration Form is governed by the Data Protection Act 1998.

Please ensure this form is completed fully and accurately.

Personal Details	
Title: _____	Forename: _____ Surname: _____
Address: _____	
Postcode: _____	
Home Tel No: _____	D.O.B: _____
Work Tel No: _____	Mobile No: _____
Email Address: _____	
General Practitioners Name: _____	
Practice Address: _____	
Tel No: _____	

Work Details and Exposure Prone Procedures	
Speciality Applied for: _____	Grade: _____
Exposure prone procedures are those where there is a risk that injury to the health worker could result in their blood contaminating a patient's open tissues. Exposure prone procedures occur mainly in surgery (including some procedures in minor surgery carried out by GPs), Obstetrics and Gynaecology, Dentistry and Midwifery. If you are unsure please contact Medacs Doctors' Occupational Health Department on 0800 442200 or email: occupationalhealth@medacs.com for further guidance.	
Will you be undertaking exposure prone procedures (EPPs) in the work for which you are applying? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Please return to Medacs Doctors Occupational Health Department at:

Medacs Doctors
The Old Surgery · 49 Otley Street · Sipton · North Yorkshire · BD23 1ET
Tel: 0800 442200 Fax: 0800 442218
www.medacs.com



Medacs Healthcare Services plc, a member of the Corporate Services Group plc Registered Office:
800 The Boulevard, Capability Green, Luton LU1 3BA
Registered in England No. 2518546

Locum's Name: _____ Date of Birth: _____

Immunisation Details						
All Applicants must indicate 'Yes' or 'No' to all parts of Questions 1-5 where indicated						
Applicants undertaking EPP must also indicate 'Yes' or 'No' to Questions 6-9						
Disease	Please provide details and evidence					
SEND 1. Tuberculosis	i	Have you had a BCG (TB) vaccination?	Yes - Date / /	No	All Applicants must arrange to have the attached TB Evidence Form completed (unless TB serology attached).	
	ii	Have you ever been treated for TB?	Yes	No		
	iii	Is there a history of TB in your family? If so, please give details	Yes	No		
	iv	Have you had a tuberculin skin test?	Yes	No		Year: Result:
	v	Have you visited, or arrived from a country outside the UK in the last 12 months? ¹	Yes	No		Date from: to: Country: Holiday/Work (delete as applicable)
	vi	In the past 12 months, have you had an unexplained cough for more than 3 weeks, fever or loss of weight?	Yes	No		
	vii	Have you had a Chest x-ray in the last year? If so, when, where and what was the result?	Yes	No		If 'Yes', you must provide a copy of the result.
SEND 2. Hepatitis B	You must attach evidence of your Hepatitis B immunity status.				All clinicians must supply evidence of HbsAB. If the result is <10iu, further testing may be needed to exclude infection. This evidence must be on an Identity Validated Sample pathology report.	
SEND 3. Varicella (chickenpox)	Have you had chickenpox or shingles?		Yes	No	If "No", please provide a copy of evidence of immune status.	
4. MRSA	Are you aware of the need to co-operate with screening in the event of an outbreak of MRSA?		Yes	No		
SEND 5. Rubella (German Measles)	We require evidence of protection. You must attach serology.				Evidence of immunity is required from both male and female clinicians whose work brings them into contact with women of child bearing age or immunocompromised patients.	
Are you likely to undertake exposure prone procedures (EPPs) in the work for which you are applying? ²			Yes	No	Consider this issue carefully. If "YES", you must address items 7, 8 & 9 below	
6. Hepatitis B Surface Antigen			Yes	No	The evidence must be issued within the last 12 months and must be on an Identity Validated Sample pathology report.	
7. HIV	You must attach evidence of your HIV pathology report		Yes	No	Locums and agency staffing undertaking EPP must provide evidence which must be on an Identity Validated Sample pathology report.	
SEND 8. Hepatitis C	You must attach evidence of Hep C serology.		Yes	No	Locums and agency staffing undertaking EPP must provide evidence which must be on an Identity Validated Sample pathology report.	
9.	Are you currently or have you ever, received anti-viral treatment for Hepatitis B or Hepatitis C?		Yes	No	Please provide details.	

All blood test results must include evidence that they have been taken by and analysed through an NHS Department of Occupational Medicine, or on an Identity Validated Sample.

- In order for us to make a proper assessment of the risk of infection, please tell us which countries you have visited, for how long, and whether it was for holiday or work? Continue on a separate page if necessary.
- Exposure prone procedures are those where there is a risk that injury to the health care worker could result in their blood contaminating a patient's open tissues. Exposure prone procedures occur mainly in surgery (including some procedures in minor surgery carried out by GPs), obstetrics and gynaecology, dentistry and midwifery. An illustrative list of exposure prone procedures is contained in *Guidance on the Management of HIV/AIDS Infected Health Care Workers and Patient Notification* (issued under cover of Health Service Circular 1998/226).

Locum's Name: _____ Date of Birth: _____

Health Record		
Please complete the following questions indicating Yes or No, ensure that all questions are answered.		
Do you consider yourself to be in good health?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you received any treatment from a health care professional in the last 2 years either as an inpatient or outpatient? (GP, Consultant, Counsellor, Physiotherapist, Complementary Therapist etc)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If you have answered yes to the above question, please provide details including dates:		
How many days were you unable to work due to ill health in the last twelve months?	_____ Days	
Do you or have you ever suffered from any of the following problems?		
Heart or Circulatory problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Back, Neck, Joint Problems or arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any blackouts, disabling giddiness, fainting attacks, or epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Psychological Problems (Depression, Stress Related Illness etc) or psychiatric disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Problems with alcohol or drug misuse	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Speech, hearing or visual difficulties	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Skin conditions (Eczema, Dermatitis etc)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Respiratory Problems (Asthma, wheezing or allergic conditions)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had any other illnesses, or important medical conditions not listed above?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is there any family history of diabetes, heart disease, stroke, high blood pressure, nervous disorder or any other hereditary disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you pregnant? (This is asked to ensure that your health and your baby's health are safeguarded)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If you have answered yes to any of the above questions please provide details including dates:		

Locum's Name: _____ Date of Birth: _____