SEQOHS

NHS
County Durham and Darlington
NHS Foundation Trust

GP Choices

Work Health Assessment

Before completing this form please read this page

Who completes what?

SECTION ONE - Manager/Appointing Officer

SECTION TWO A & B - Successful candidate

Clinical staff must submit immunisation evidence. Failure to do so may delay the clearance process.

SECTION THREE - Successful candidate who has declared health issues

Send all completed paper work to:

Occupational Health Nurse, GP Choices, Appleton House, Lanchester Road, Durham, DH1 5XZ.

It is advisable to copy this paper work before sending and add the senders name & address to the back of the envelope.

The following guidelines will assist managers in the completion of the Pre-Employment Risk Assessment Form. Further information and advice, if required, can be obtained from the Occupational Health Service;

COSHH RISK ASSESMENT	Staff who may be at risk of infection with the following has been assessed under COSHH and is considered significant, warranting protection of the employee by vaccination in spite of other measures taken. **NB staff who may be working in close proximity to clients i.e. in the personal/ intimate space, or carrying-out treatments or interventions.** **Please refer to Regulation 12 CQC guidelines (this also includes Admin/Clerical Staff)**
Non-clinical patient contact	Staff who have face-to-face contact with patients with no 'hands on' clinical involvement
Driving (except to and from main place of work)	Those staff whose employment requires them to transport clients/patients or supplies on behalf of their Employer
Manual handling or postural demands	This includes patient and non-patient handling, lifting, carrying and lowering, repetitive bending and twisting, prolonged standing, or maintaining an awkward posture.
The use of Display Screen equipment	This involves continuous periods of an hour or longer per day where the worker has little or no discretion on when or whether to use the screen for their work.
Exposure prone procedures	Those where there is a risk that injury to the worker may result in exposure of the patient's open tissues to the blood of the worker. These procedures include those where the worker's gloved hands may be in contact with sharp instruments, needles, or sharp tissue (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. (NB venepuncture, PR AND PV general examinations are NOT an exposure prone procedure)
Vulnerable groups of patients	This may include staff who are required to work with children, immuno-compromised patients, the elderly, or patients with mental health problems

SECTION one

APPOINTING OFFICER/MANAGER TO COMPLETE THIS SECTION

You **MUST** complete all of the information in Section one. Send/give this form to the successful **applicant only** (not to short listed applicants). Any offer of employment should be made subject to a satisfactory health assessment.

Details of absence records should be requested when taking up references from previous employers.

Applicant Name: Mr/Mrs/Miss/other	**Date of Birth:** **Gender:**
Previous/Birth Surname/Names:	**Home Tel No:**
Address:	**Email Address:**
	Mobile /Contact No:
	Location: (Employer & address)
Post Applied for:	**Anticipated Start Date:**

ROLE RISK ASSESSMENT- The following activities are an integral part of the job.

1.	Direct clinical contact	2.	Exposure Prone Procedures (see appendix 1)
3.	Non clinical contact	4.	Hours: _____/week
	a) clinics		a) nights
	b) patient's homes		b) early/late
	c) other		c) on-call
5.	Handling patients	6.	Handling loads up to _____kg
7.	Driving	8.	Working with children
9.	Using a VDU	10.	Working with pregnant women
11.	Chemicals/Detergents	12.	Lone Working
		13.	Animals (dogs, cats, birds etc.) in client home environment

COSHH RISK ASSESMENT - Please identify if COSHH/Risk Assessments indicate a program of health surveillance is required. Risk of infection with the following has been assessed under COSHH and is considered significant, warranting protection of the employee by vaccination in spite of other measures taken. **(See appendix 1) THIS SECTION MUST BE COMPLETED. Please refer to Regulation 12 CQC guidelines (this also includes Admin/Clerical Staff)**

	Measles, Mumps & Rubella	Tuberculosis	
	Hepatitis B	Hepatitis A	
	Varicella	Influenza	
	Whooping cough	Other……..	

Manager/Appointing Officer at GP Practice:
Practice Name:
Name (please print): **Signature:** **Date:**
Anticipated start date:

SECTION two (a) - To be completed by Prospective Employee:

Your Name must be entered on every sheet; this allows identification if sheets are separated (see footer).

Information for the Prospective Employee:

Your appointment is subject to an assessment of your fitness for this work. The purpose of this is to:

- Identify any health problems or disabilities that may make the proposed job difficult or unsafe for you or others.
- Enable us to assess what adjustments to the job may be needed to enable you to work, if you have a health problem or disability.

Please read the following questions carefully, and then tick whichever of the two statements is appropriate for you and sign the declaration below. To preserve medical confidentiality you are **not required to identify any conditions/illnesses you may or may not have on this part (section two) of the form.**

Have you previously been employed by a GP or Dental Practice within County Durham & Darlington? - **Yes/No**

If **Yes**, provide details:

SECTION two - To be completed by Prospective Employee:

Do you have any condition or disability that could affect your ability to undertake any of the activities of the proposed post, including shift patterns, without adjustments?	**YES/NO**
Have you ever had any illness / impairment / disability which may have been caused or made worse by your work?	**YES/NO**
Has your work (hours or duties) ever been modified or have you had to leave a job because of a health problem?	**YES/NO**

Have you ever been affected by one of the following health problems:

Diabetes?	**YES/NO**
Epilepsy?	**YES/NO**
Musculoskeletal problems or back pain?	**YES/NO**
Skin disorders, e.g. hand eczema?	**YES/NO**
Chest problems, e.g. asthma?	**YES/NO**
Heart, circulation or blood pressure problems?	**YES/NO**
Impairments of vision (other than to wear glasses)?	**YES/NO**
Impairments of hearing?	**YES/NO**
Depression, psychiatric or nervous/stress problems?	**YES/NO**
Substance or alcohol misuse?	**YES/NO**
Any other problem that you may wish to bring to the attention of GP Choices Staff	**YES/NO**

DECLARATION- SECTION two (a)

1.	**YES**	☐	I would answer YES to one or more of the above questions. **ACTION** – Please sign below and complete section 3
2.	**NO**	☐	None of the above applies to me. **ACTION** – please sign below and return to GP CHOICES, these completed forms will then be sent to your Manager/Appointing Officer identified in Section 1.

* In signing this questionnaire you confirm that all the information provided is true to the best of your knowledge true and correct. If it is subsequently shown that medical information has not been disclosed by you, or has been misleading or false, the offer of employment may be withdrawn, or you may be subject to disciplinary proceedings, which could result in dismissal.

*I undertake to submit, **if required**, to a further assessment including a medical examination and / or investigation by GP ChoicesOoccupational Health staff.

*In signing this for, I confirm my explicit consent within the meaning of the General Data Protection Regulations 2018 for GP Choices to process my personal information which may include electronic storage of my personal and medical information. I understand that my information will be held securely and if I wish to gain access to my medical information I can do so by requesting it in writing.

Name (Block capitals):……..

Signature: ……Date:……..

If you have declared 'YES' to any of the above questions then you MUST complete Section three.

If you have answered No to all the questions above then a copy of pages 1, 2 & 3 (together with this signed declaration) will be sent to your appointing manager for your personal files. GP Choices will retain the original copy in your Occupational Health files with your immunisation declaration.

SECTION two (b) Immunisation and Communicable Diseases Questionnaire (ALL new staff).

Clinical staff MUST provide documentary evidence of any immunisations of screening for this post (i.e. Hep B antibody test, HIV, HEP C testing)

Are you a new or returning to healthcare work (Clinical staff)? Delete as appropriate

a) New to health care
b) Returning to health care work?

Have you ever had any of the following diseases?	YES	NO	DETAILS(dates)
Chicken Pox			
Hepatitis A, B or C			
Shingles			
Herpes (cold sores)			
Measles			

Have you ever had a chest x-ray?	**YES**	**NO**
If YES why and where was this done?	**YES**	**NO**
Was the chest x-ray normal?	**YES**	**NO**
Have you had a cough for more than three weeks in the past year?	**YES**	**NO**
Have you had any unexplained weight loss in the past year?	**YES**	**NO**
Have you had any persistent high temperature/fever in the past year?	**YES**	**NO**
Have you suffered with night sweats in the past year?	**YES**	**NO**
Have you or anyone in your family had Tuberculosis?	**YES**	**NO**
Are you being followed up for contact with infectious Tuberculosis?	**YES**	**NO**
Have you had or are you receiving treatment for Tuberculosis?	**YES**	**NO**
Do you come from or have you lived in a Country with a high incidence of Tuberculosis?	**YES**	**NO**
Have you worked abroad within the last 12 months?	**YES**	**NO**

Have you ever been immunised against any of the following?	YES	NO	DON'T KNOW
Tuberculosis – BCG			
Tuberculosis – Skin prick Test			
Rubella - (German measles)			
Poliomyelitis			
Diphtheria/ Triple Vaccine			
Tetanus – Full Course			
Tetanus – Booster			
Hepatitis B			
Did you have a blood test following the course of vaccine?			
Hepatitis B – Antibodies			
Hepatitis B – core Antibodies			
MMR 1 MMR 2			
Varicella vaccine			
Have you ever had a severe/adverse reaction to any vaccine given?			

Have you ever been exposed to hazardous substances? e.g. chemicals, asbestos or hazardous conditions e.g. noise?
YES / NO

		Details	Effect on performance/attendance
Are there any circumstances, illnesses or conditions you have which could affect your performance at work and/or result in absence from work?	**YES**		
	NO		

Do you consider that you have a disability? YES/NO If 'YES', please give details.

Details of Disability	Details of adjustment you consider may be required for you to undertake the position

Certain lifestyle factors are associated with future poor health. Please answer the following for your own benefit:	Y/N	Would you like advice to improve this?
Are you overweight for your height?		

Do you smoke?		
Do you exercise for 20 minutes three times weekly to the point where your pulse and breathing are speeded up?		

For night workers only A&B i.e. staff whose duties include 3 hours or more between 11 p.m. and 6 a.m.

	Do you suffer from?		Dates	Details of condition and treatment
A	Any medical condition affecting sleep?	**YES**		
		NO		
B	Any chronic chest disorders where night time symptoms may be particularly troublesome?	**YES**		
		NO		

CONSENT & STATEMENT ***

* In signing this questionnaire you confirm that all the information provided is true to the best of your knowledge true and correct. If it is subsequently shown that medical information has not been disclosed by you, or has been misleading or false, the offer of employment may be withdrawn, or you may be subject to disciplinary proceedings, which could result in dismissal.

*I undertake to submit, if required, to a further assessment including a medical examination and / or investigation by GP Choices occupational Health staff.

In signing this for, I confirm my explicit consent within the meaning of the General Data Protection Regulations 2018 for GP Choices to process my personal information which may include electronic storage of my personal and medical information. I understand that my information will be held securely and if I wish to gain access to my medical information I can do so by requesting it in writing.

Signed: **Date:**

SECTION three only to be completed if answering 'Yes' in section two (a)

To be completed by Prospective Employee

Please complete this form in full; any missing information may delay your clearance

	YES	NO	If YES please give details (including leaving date)
1. Have you been employed previously by a GP/Dental Practice in County Durham & Darlington?			
2. Have you ever left work on medical grounds from any form of employment?			
3. Please give the Job Title of your most recent employment			
4. Approximately how many days and occasions of sickness absence have you had in the past 24 months or, if unemployed, on how many days and occasions would you have been unable to work (if none, please state '**NONE**')? Please give reason for absence on each occasion. (Continue on a separate sheet as necessary)			

Number of days	Date	**NO**	If yes please give details (including leaving date)

5. Are you currently taking any medication or undergoing any course of treatment? **YES/NO**

If '**YES**', please give brief details continuing on a separate sheet where necessary:

Medical History

Please tick YES/NO. If the answer to any of the following questions is "YES" please give details: extra space is available on the last sheet for this.	**YES**	**NO**	DETAILS(dates, diagnoses, restrictions on your activities, treatment, duration, recovery)
a) Are you receiving any treatment: injections, medicine, pills/tablets from a Doctor or other health professional?			
Have you ever been treated in hospital or Out Patients Department?			
Have you ever suffered from or had a work related disease or accident?			
Have you ever been retired or left a job because of ill-health?			

Do you consider yourself to have a disability? If so what adjustments if any have you needed to work or daily living?	

Do you suffer from or have you ever had any of the following: If "**YES**" please give details: *extra space is available on the last sheet for this.*	**YES**	**NO**	Details (dates, diagnoses, restrictions on your activities, treatment, duration, recovery)
Severe or prolonged headaches, migraines or face pains?			
Eye Disease?			
Colour Blindness?			
Do you wear spectacles or contact lenses? Reason? Please indicate which you use?			
Ear trouble, disease or hearing problems?			
Have you ever had a noisy hobby e.g. shooting?			
Have you ever worked in a noisy environment?			
Do you wear a hearing aid?			
Epilepsy, fainting attacks, blackouts or attacks of giddiness?			
Chest Disease: bronchitis, pneumonia, pleurisy, asthma etc.?			
Raised blood pressure?			
Heart or circulatory problems?			
Back or neck deformity, disease, injury or pain, whiplash, sciatica etc.?			
Rheumatism, arthritis or joint or muscle problems?			
Bladder, kidney or urinary problems?			
Blood disorders, hepatitis, anaemia, jaundice?			
Diabetes (recent onset or childhood)			
Psychiatric illness or nervous trouble?			
Stress, depression or anxiety even if mild?			
Eating problems or disorder including Anorexia, Bulimia or others?			
Alcohol, drugs or substance use/misuse?			
Stomach or digestive problems e.g. ulcer, hiatus hernia, gallstones, celiac disease?			
Any skin problems e.g. dermatitis, eczema, psoriasis?			
Any allergies e.g. to drugs, latex, nuts, fruits, animals, hayfever etc.			
Have you or any near relative suffered from Tuberculosis (TB)?			
Have you ever had or do you have a persistent cough, weight loss, night sweats or			

coughed up blood?			
Any other illness or injury i.e. road traffic accident or attendance at A & E Department?			

Section three CONSENT & STATEMENT ***

* In signing this questionnaire you confirm that all the information provided is true to the best of your knowledge true and correct. If it is subsequently shown that medical information has not been disclosed by you, or has been misleading or false, the offer of employment may be withdrawn, or you may be subject to disciplinary proceedings, which could result in dismissal.

I understand that should additional information be required, GP Choices occupational health will notify me of their request by phone or in writing, if following contact and or consultation a report or disclosure is required then :-

- I consent to provision of written and/or verbal report(s) to Management, based upon my Occupational Health consultation(s), and subsequent developments in my case.

- I understand that the report(s) will contain only medical information sufficient for Management to understand work-related issues such as: sickness absence timescales; work restrictions; modified duties; rehabilitation advice; safety responsibilities; timing/dates of medical appointments; disciplinary matters; disability income and pension scheme issues; disability discrimination matters; medico-legal issues or similar topics; in relation to my employment.

- In signing this for, I confirm my explicit consent within the meaning of the General Data Protection Regulations 2018 for GP Choices to process my personal information which may include electronic storage of my personal and medical information. I understand that my information will be held securely and if I wish to gain access to my medical information I can do so by requesting it in writing.

Signed: **Date:**