

# Occupational Health Declaration Form



This 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.

The information is assessed by our Occupational Health Department, who will advise Medacs Healthcare on your fitness to practice. Medacs Healthcare may disclose this information to clients for the purpose of finding you suitable assignments.

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

You may be contacted by the Occupational Health Department for further information, or be asked to attend a medical examination. 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: \_\_\_\_\_

General Practitioners Name: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Tel No: \_\_\_\_\_

## Health Record

Please complete the following questions indicating Yes or No. If YES please give details on a separate sheet.

	Yes	No
Respiratory problems (Asthma, Tuberculosis, Persistent Cough etc)	<input type="checkbox"/>	<input type="checkbox"/>
Skin Problems (Eczema, Dermatitis etc)	<input type="checkbox"/>	<input type="checkbox"/>
Psychological problems (depression, stress related illness etc)	<input type="checkbox"/>	<input type="checkbox"/>
Back or Neck problems	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>
Uncorrected visual problems	<input type="checkbox"/>	<input type="checkbox"/>
Problems with upper or lower limbs	<input type="checkbox"/>	<input type="checkbox"/>
Liver conditions (Hepatitis)	<input type="checkbox"/>	<input type="checkbox"/>
Speech problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to food or drugs	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking any prescribed or over the counter medications?	<input type="checkbox"/>	<input type="checkbox"/>
Are you waiting/receiving any treatment for a physical or mental health problem?	<input type="checkbox"/>	<input type="checkbox"/>
Have you received any treatment from a healthcare professional in the last 2 years either as an inpatient or outpatient? (GP Consultant, Counsellor, Physiotherapist, Complementary, Therapist etc)	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any other illnesses, other than childhood illnesses, not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
Have you any conditions that may affect your ability to undertake nightshifts?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a health condition that was made worse by work?	<input type="checkbox"/>	<input type="checkbox"/>

## Immunisation Details

Have you had any of the following illnesses / diseases? (Please indicate Yes or No and give year).

	Yes	No	Date	
Rubella (German Measles)	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Varicella (Chicken Pox)	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Have you had a TB test?	<input type="checkbox"/>	<input type="checkbox"/>	_____	Country: _____
Heaf / Tine / Mantoux (Delete as appropriate)	<input type="checkbox"/>	<input type="checkbox"/>	_____	

Have you ever had any of the following immunisations? (Please indicate Yes or No and give year).

	Yes	No	Date
Rubella (German Measles)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	_____
Varicella (Chicken Pox)	<input type="checkbox"/>	<input type="checkbox"/>	_____
MMR (Mumps, Measles, Rubella)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have a visible BCG Scar?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	_____

If you wish to work in a hospital environment you must provide an up to date original certificate of these immunisations; TB (or evidence of scar), Rubella, Hepatitis B and Varicella (or written confirmation that you have had Chicken Pox).

Please tick

SEND

☐

## Hepatitis B

Please tick

SEND

☐

You must provide a copy of the most recent actual UK pathology report showing titre level (>100lu/l if possible) or antigen status if titre level <100lu/l.

You must also provide a printed Occupational Health / GP Immunisation record including the following information:

	Yes	No
Dates of primary course of Hepatitis B vaccine	<input type="checkbox"/>	<input type="checkbox"/>
Post course titre levels	<input type="checkbox"/>	<input type="checkbox"/>
Dates of all subsequent booster doses	<input type="checkbox"/>	<input type="checkbox"/>

## Declaration

I confirm that I have read this document fully and that all the information given to Medacs Healthcare 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 Healthcare if my circumstances alter. I understand that a copy of my vaccination records / immune status may be sent to any hospital where I will be employed.

I have read and agree to adhere to the Medacs Healthcare Terms of Engagement.

I give my permission for Medacs Healthcare's Occupational Health to contact my Occupational Health Department, Specialist or GP to seek further information on any aspect of the information contained within this Health Statement, and this consent is valid for a period of three months from the date below.

I understand and agree to Medacs Healthcare disclosing this information to their clients for the purposes of finding me assignments.

I understand my Health Statement will be processed by Medacs Healthcare's Occupational Health Department. I give permission for any information or documents supplied by me to be used to secure a position by Medacs Healthcare on my behalf.

Print Name: \_\_\_\_\_ Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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P09-v1.Feb 2008



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