**CONFIDENTIAL**

**PRE-EMPLOYMENT HEALTH QUESTIONNAIRE (SELF-CERTIFIED)**

**Guidance notes**

The purpose of the Pre-employment Health Questionnaire is to provide information about your

medical history which will assist in the following ways:

* to ensure that you are medically suitable for the proposed job;
* to advise, where necessary, on any reasonable adjustments to your work or workplace to

suit you, so that any underlying health problem is not made worse by work

* to ensure that you do not have a medical condition which could pose a risk to your safety or

to that of your colleagues, residents or members of the public.

* to help us identify if there is a risk of developing a work related illness from any hazards in

the proposed workplace.

Pre-employment Screening takes into account both current and previous health factors.

The medical data on this form will remain **confidential**. The medical contents of this form

will not be disclosed to anyone without your explicit or written consent.

Please ensure you answer all the questions. Failure to fully complete this questionnaire will

result in a delay to your health clearance and subsequent start date.

|  |
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| **To be completed by the recruiting officer**The candidate is expected to work in an environment assessed as below: |
| Recruiting Officer’s name:  |
| Job title: |
|  |
| Will the applicants’ duties involve any of the following:Working with children ❑ Working in a noisy area ❑Handling chemicals ❑ Manual handling ❑Working at heights ❑ Night workers ❑Body fluid e.g. blood, urine ❑ Driving 🞏Working with computer screen ❑ Excess dust or fumes ❑Noise above 80 dB/A ❑ Use of vibrating equipment ❑Handling/preparing food ❑  |

**Section 1: To be completed by the Applicant**

**PERSONAL DETAILS**

Surname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: Male / Female \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maiden / Previous Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE: Forms will be shredded or destroyed and new forms sent out if the Manager has not completed Section 1 of this form.**

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| **Section 2: To be completed by the Applicant****DETAILS OF JOB APPLIED FOR** |
| Job title: |
| Directorate:  |

**SECTION 3: To be completed by the Applicant**

**MEDICAL HISTORY**

**Please read the following statements and tick Yes or No.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Health Question** | **Yes** | **No** | **If Yes, give details with dates here***Please continue on a separate sheet of paper if necessary.* |
| 1 | Do you need any special aids/adaptations to assist you at work, whether or not you have a disability? |  |  |  |
| 2 | Do you have a medical condition – physical or mental or a disability which may affect your ability to carry out your proposed work? |  |  |  |
| 3 | Are you receiving, or waiting for, treatment or an investigation of any kind at present? |  |  |  |
| 4 | Have you ever left a previous employment through ill-health or a work related injury or condition? |  |  |  |
| 5 | Have you been retired or ever had your contract of employment terminated due to ill health? |  |  |  |
| 6. | Have you ever been treated for:* Mental Health problems (including anxiety, depression, eating disorders, alcohol or drug abuse)?
* Back Pain?
* Musculoskeletal problems (such as arthritis, pains in arms or legs, restricted movement)?
* Skin problems (including eczema or dermatitis)?
* Epilepsy?
* Diabetes?
* Asthma
* Cough which lasted for more than 3 weeks or have been investigated for TB?
* Other
 |  |  |  |
| 7. | Do you have any allergies? (including sensitivity to medicines, foods or other substances, such as Latex) |  |  |  |

None of the above applies to me

*If you have answered* ***Yes*** *to any of the questions you may be asked to undertake a full medical assessment by a doctor.*

**Failure to disclose a condition that you know might affect your work could limit your rights and adversely affect our ability as an employer to implement reasonable adjustments to assist you.**

**DECLARATION**

I confirm that the declaration provided above is correct to the best of my knowledge, and I understand that making a false declaration could affect my employment with St Helena Government.

**Name**………………………………………………………………………………………….

**Signature**……………………………………………………**Date**………………………….

**Post recruited to**……………………………………………………………………………

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| **SECTION 4: FOR MANAGEMENT USE ONLY** |
| Further information on health required | Date Requested | Date Received | To be signed and approved by Director |
|  |  |  |
| For doctor’s appointment |  |  |  |
|  | Fit | Fit with restrictions | Unfit |
| Final Outcome: |  |  |  |