**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.

Section 1 will be completed by the Recruiting Manager prior to being sent to you to complete Section 2 and 3. 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.

On completing the form, please return to your Human Resources contact.

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| **SECTON 1: To be completed by Recruiting Manager** |
| Recruiting Manager’s Name  |  |
| Job title  |  |
| Portfolio/Directorate |  |
| The candidate has been offered the position of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ within the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Portfolio/Directorate and is expected to work in an environment assessed below. |
| The candidates’ duties will involve 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 ❑  |

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| **SECTON 2: To be completed by Candidate** |
| Surname  |  | First Name |  |
| Address  |  |
| Gender | Male |  | Female |  |
| Maiden/Previous Name |  |
| Date of Birth |  |
| Home Telephone |  | Work Telephone |  |
| Mobile Number |  | Email Address |  |

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| **SECTION 3: MEDICAL HISTORY** |
| **To be completed by candidate. Please read the following statements and tick Yes or No** |
|  | **Health Question** | **Yes** | **No** |
| 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 | Have you previously had any investigations or treatments relating to a physical or mental health condition (e.g. back pain, eating disorders, arthritis, asthma etc.)? |  |  |
| 4 | Are you having, or waiting for any medical treatment or investigations relating to a physical or mental health condition (e.g. back pain, eating disorders, arthritis, asthma etc.)? |  |  |
| 5 | Have you ever left a previous employment through ill-health or a work related injury or condition? |  |  |
| 6 | Have you been retired or ever had your contract of employment terminated due to ill health? |  |  |
| 7. | Do you have any allergies? (including sensitivity to medicines, foods or other substances, such as Latex) |  |  |

None of the above applies to me

*You are not obliged to provide us with any further details in relation to any of the questions above where you may have answered* ***Yes.*** *If you have answered* ***Yes*** *to any of these questions we will refer this to the Chief Medical Officer for a further assessment.*

*If you feel it would be helpful for us to know about anything in relation to your responses, particularly on workplace adaptions at this stage, you can provide further details below:*

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**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 the Public Service

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

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

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| **SECTION 4: FOR HR USE ONLY** |
| I have reviewed the information provided above and no further medical assessment is required/a further medical assessment is required | HR Business Partner | Date Received |
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| **SECTION 5: FOR CMO USE ONLY** |
| Further information on health required: | Date Requested | Date Received |
|  |  |
| For doctor’s appointment |  |  |
| Final Outcome: | Fit |  | Fit with restrictions |  | Unfit |  |

On completion of the Medical Assessment, the CMO will advise Central HR & OD.