NHS
Airedale
NHS Foundation Trust

Employee Health and Wellbeing Services
Tel. 01535 294401

WORK HEALTH ASSESSMENT FORM FOR CLINICAL STAFF

FOR HEALTHCARE WORKERS INVOLVED IN PATIENT CARE / PATIENT CONTACT / BODY FLUID SAMPLE HANDLING (INCLUDING LABORATORY WORKERS)

This section to be completed by HR Advisor / Manager and given to successful candidates following a job offer:

POST APPLIED FOR: …… EMPLOYER: ……..

DEPARTMENT: …….. LOCATION: ……

MANAGER: …… START DATE: ……

HR ADVISOR: ……..……

Your answers to this questionnaire will be **CONFIDENTIAL** to Employee Health and Wellbeing Services and will not be given to anyone else without your written permission. The purpose of the questionnaire is to see whether you have any health problems that could affect your ability to undertake the duties of the post you have been offered or place you at any risk in the workplace. We may recommend adjustments or assistance as a result of this assessment to enable you to do the job.

Before health clearance is given for employment you may be contacted by a member of Employee Health and Wellbeing Services team and you may need to be seen by an Employee Health & Wellbeing Nurse Advisor or Physician.

Please help us to help you by completing the questionnaire as fully as possible. Please complete this form in **BLACK** ink and block capitals.

Title: Ms / Miss / Mrs / Mr / Dr / Professor:		Male: ☐	Female: ☐
Surname / Family name:		First name:	
Previous names (if applicable):		Date of birth:	
Are you new to working for the NHS? Yes ☐	No ☐	NHS NUMBER: **(essential – please clarify with GP if unsure)**	
Have you ever worked / trained here? Yes ☐	No ☐		
Home Address:			
Post code:		E-mail address:	
Mobile:		Tel home:	

GENERAL HEALTH	**YES**	**NO**
Do you have any health condition or disability (physical or psychological) which might impair your ability to undertake effectively the post offered?		
Do you have a health condition or disability (physical or psychological) which might affect your work and which might require special adjustment?		
Have you ever had any health conditions / illness / impairment / disability (physical or psychological) which may have been caused or made worse by your work?		

IMMUNISATION HISTORY - ALL STAFF TO COMPLETE THIS SECTION

Tuberculosis		**YES**	**NO**
(a)	Do you have a cough which has lasted for more than 3 weeks?		
(b)	Do you have unexplained weight loss?		
(c)	Do you have an unexplained fever?		
(d)	Have you had tuberculosis (TB) or been in recent contact with open / pulmonary TB?		
	If **yes**, please give details below:		
Have you recently travelled or lived outside of the UK in the last 12 months?			
	If **yes,** please give details below: Please provide specific information of countries visited where increased risks of TB, e.g. India/Pakistan/South Africa/Nigeria (i.e. Non-European countries)		
Have you had a BCG vaccination in relation to Tuberculosis?			
	If **yes**, please provide approximate date below:		
Chickenpox			
(a)	Have you ever had chickenpox or shingles?		
(b)	Have you evidence of immunity (blood test result)? *(If **yes**, please provide copy information*)		
(c)	Have you had Varicella vaccinations?		
	If **yes**, please provide dates of vaccinations below: 1: 2:		
Measles / Rubella			
(a)	Have you had MR or MMR vaccines?		
	If yes, please provide dates of vaccinations below: 1: 2:		
(b)	Have you evidence of immunity (blood test result)? *(If **yes**, please provide copy information*)		
Hepatitis B			
(a)	Have you had vaccinations against Hepatitis B?		
	If yes, please provide dates of vaccinations below: 1: 2:		
(b)	Have you evidence of immunity to Hepatitis B (blood test result)? *(If **yes**, please provide copy information)*		

Please remember to attach evidence of blood test results / vaccinations dates

EXPOSURE PRONE PROCEDURES (EPP)

Exposure Prone Procedures (EPP) are those procedures where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissue (e.g. 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.

Under Department of Health guidelines, most healthcare workers (depending on original employment dates) and all trainees on placement who perform exposure prone procedures, e.g. all foundation doctors Y1 & Y2, Drs in Surgery, Drs in Obstetrics and Gynaecology, Drs in Accident and Emergency, Drs in Cardiac Catheterisation Lab, qualified Theatre Nurses, ODP's, Midwives, Dentists & Hygienists, staff in Cardiac Catheterisation Lab, **must demonstrate freedom from infection of Hepatitis B, Hepatitis C and HIV** in the form of a blood report from an accredited laboratory, which clearly states to be a 'validated sample' as per DH guidelines.

The results of these checks must be available before clearance can be authorised for you to undertake exposure prone activities.

Please ensure that if you have copies of these tests that they are attached to this form.

If the required evidence cannot be provided the appropriate checks* will be made through Employee Health and Wellbeing Services and health clearance for EPP work will be delayed until these results are processed. Please contact the Department on 01535 294401 to arrange an appointment.

	YES	NO
Will you be performing EPP?		
Are you attaching evidence of blood test results / vaccination dates?		
Please provide below the approximate date that you were first employed to carry out exposure prone procedures:		

*** To comply with the Department of Health's standard for Identified Validated samples (IVS) you will be asked to show formal photographic ID, i.e. valid driver's licence, passport or Airedale NHS Foundation Trust ID for this procedure.**

DECLARATION

I declare that to the best of my knowledge and belief the statements I have made on this form are true and complete.

I understand that any false statement or failure to declare information may result in the withdrawal of an offer of employment or dismissal.

Signed: _____ Date: _____

Employee Health and Wellbeing Nurse Advisor to complete:

Comments: ……..

……

……

1 Accept: Yes / No

2 Pass slip sent: Yes / No

3 Refer to Physician Yes / No

4 Discuss with Physician: Yes / No

Signed: .....

Date: ……..