Branch Name	
X2 number	

Confidential Work Health Assessment

Reed actively promotes the benefits of a diverse workforce and is committed to upholding equal opportunities for all, irrespective of sex, race, disability, religion or belief, sexual orientation, age, marital/civil partnership status, pregnancy or maternity and gender reassignment.

The purpose of this confidential questionnaire is to establish whether you have any health problems that could affect your ability to undertake your working duties. Following this assessment, we may call you to confirm your health and recommend adjustments, modifications or assistance to support you into work. Our aim is to promote and maintain the health of all people at work.

Please help us to help you by completing the questionnaire as fully as possible, giving full details including dates, treatment and if the health is now resolved or ongoing, if you do not give full details it will delay your assessment as an Occupational Health Nurse will need to speak to you for further clarification. Attach additional sheets of paper if necessary.

Candidate to complete			
Title:		First name:	
Surname/Family name:		DOB:	
Previous names (if applicable):		Male Female Other	
Home phone number:		EPP worker	Yes ☐ No ☐
Mobile phone number:		Work phone Number:	
Home Address:		GP Address	
Occupation / Job Title:			

Please answer each question below fully, but only if it is relevant to the specific role(s) for which you will be applying. If you are unsure about this an Occupational Health Nurse will call you to discuss - please see Question 1 below.		
	Yes	**No**
1. Have you got a current health issue that you would like to discuss with an Occupational Health Nurse?	☐	☐
2. Do you have any illness or impairment or disability (physical or psychological) which may affect your work? If yes, please give details below.	☐	☐

3. Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?	☐	☐
4. Are you having any treatment or waiting for any treatment (including medication) or investigations at present which may affect your work? If your answer is yes, please provide further details of the condition, treatment and dates below	☐	☐
5. Do you think you may need any adjustments, modifications or assistance to enable you to work or to attend an interview process? If yes, please provide details below.	☐	☐

IMMUNISATION AND INFECTIOUS DISEASE HISTORY **We are required to ask you about the following, as it is relevant to the role(s) for which you will be applying.**		
Have you suffered from any of the following?	**Yes**	**No**
6. Methicillin resistant staphylococcus aureus (**MRSA**)	☐	☐
7. Clostridium difficile (**C-Diff**)	☐	☐
8. Have you ever had chicken pox or shingles? Date:	☐	☐
Do you have any of the following?		
9. A persistent cough that has lasted for more than two weeks?	☐	☐
10. Coughing up blood?	☐	☐
11. Unexplained weight loss?	☐	☐
12. Unexplained fever?	☐	☐
13. Feeling generally unwell?	☐	☐
14. Night sweats?	☐	☐
15. Have you been in close contact with a friend or relation found to be suffering from Tuberculosis within the last two years?	☐	☐
16. Have you been given the HEAF /TINE/ MANTOUX test? If yes, please give the date and grade of response if known Date Grade	☐	☐
17. Have you had BCG Immunisation (for tuberculosis)? Date:	☐	☐
18. Have you lived outside the UK or had an extended holiday outside the UK in the last year?	☐	☐
19. If yes please list all of the countries that you have been to and the length of time you spent in each one.		
20. Have you travelled to an Ebola affected country in the last 21 days? If you have been to an Ebola affected area a risk assessment will be made and further guidance given to you.	☐	☐
If you have indicated yes to any of the above questions you must provide further details, failure to do so will result in the form being returned/rejected.		

	Yes	No
Please indicate if any of the following apply to you:		
21. Do you have any reason to believe that you maybe immunosuppressed (where the immune system is weakened), either as result of infection, illness or medication?)	☐	☐
22. Have you ever come into contact with any Blood Bourne Viruses? Including needle stick injuries.	☐	☐

Immunisation History	**Yes**	**No**	**Date**
23. Triple vaccination as a child (Diptheria / Tetanus / Whooping cough)	☐	☐	
24. Polio	☐	☐	
25. Tetanus	☐	☐	
26. Have you been vaccinated against Hepatitis B? (If Yes is ticked please give dates below)	☐	☐	

Course:	1		2		3	
Boosters:	1		2		3	

The General Data Protection Regulation (GDPR) (EU) 2016/679		
REED work in partnership with Healthier Business UK Ltd. All information supplied by you will be held in confidence by Healthier Business UK Ltd. Records will be retained electronically in accordance with best practice and the requirements of the General Data Protection Regulations at which time it may be subject to audit. Your data may also be cross referenced should you have registered with other Clients of Healthier Business UK Ltd. Your personal data may be required to be seen by an occupational health advisor or physician, however it will not be shown, nor their contents shared with anyone - including Managers, Human Resources Advisors, GP, Specialist's or third party's - without your explicit consent. You have the right of erasure (the right to be forgotten), withdrawal of consent and refusal of consent without detriment. The only exceptions to this may be a court order for release of records in a judicial dispute or where there is a public responsibility obligation.		
Consent is a process rather than a one off decision, for consent to be valid, it must be voluntary and informed. You have the right to withdraw your consent at any stage of the process, either verbally or in writing.	**Yes**	**No**
Do you consent to this questionnaire and your immunisation reports being assessed by an Occupational Health Advisor for the purpose of providing a Fitness to Work Certificate?	☐	☐
Do you consent to our Occupational Health Advisors making recommendations to your employer/agency to assist with your ability to carry out your perspective role?	☐	☐
If you consent to recommendations being made to your employer/agency do you wish to see a copy of the recommendations prior to their release to your employer/agency?	☐	☐

Recommendations	**Yes**	**No**
I understand that following this assessment, recommendations may be provided to assist my health at work	☐	☐

I give consent for the Healthier Business UK Ltd to make recommendations and for my employer/agency to provide these recommendations to my placement	☐	☐
I would like to see a written copy of any recommendations Healthier Business UK Ltd may make before my employer/agency provide them to my placement	☐	☐

APPLICANT'S DECLARATION

I declare that, to the best of my knowledge, all answers and statements I have given are true.

I understand that Reed may pass information contained within this form to their appointed third party Occupational Health Company for the purpose of additional screening. I hereby consent to Reed passing such information (together with any related documentation) to such organisations and for this information to be used and retained by them for the above purposes.

I am aware that it is my responsibility to provide evidence of immunity to HepB, measles, rubella, chicken pox, Tuberculosis and if an EPP worker HIV, HepB antigen and Hep C.

Signature:		**Print name:**	
Date:			

Self-Declarations		
Declaration 1 - Chicken pox (Varicella)		
Have you had the illness chicken pox in the past?	**Yes** ☐	**No / Unsure** ☐ Please note, if you are unable to confirm that you have had chicken pox (varicella) you will need to agree to undertake a blood test to determine your immunity. If it is determined that you are not immune, you will require a vaccination to work through Reed Health and Care

Declaration 2 - Exposure Prone Procedures (All Health Care Workers and Allied Professions)		
Exposure prone procedures are those invasive procedures where there is a risk that injury to the worker may result in the exposure of the patient's open tissues to the blood of the worker. These include procedures where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissues 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. However, other situations, such as pre-hospital trauma care and care of patients where the risk of biting is regular and predictable, should be avoided by health care workers restricted from performing exposure prone procedures. Taken from 'Consultation document – Guidance on health clearance for serious communicable diseases: New health care workers':		
Do you undertake Exposure Prone Procedures (EPPs) as part of your current scope of practice?	**Yes** ☐ If Yes - Please provide the following blood test result, all of which should be identity validated samples. • **HIV** • **Hepatitis B antigen** • **Hepatitis C**	**No** ☐ I will inform Reed Nurse / Doctor and complete the necessary occupational health tests if this situation is likely to change.

Declaration 3- Electromagnetic Fields at Work (All Health Care Workers and Allied Professions)		
Sources of EMF devices such as MRI equipment may pose a risk to workers with active implanted, passive implanted or active body worn medical devices (e.g. cardiac pacemakers/orthopaedic implants or joints/insulin pumps), as well as to expectant mothers. We therefore encourage workers to consider if they may be affected. Taken from: 'A Guide to the Control of Electromagnetic Field at Work Regulation 2016"		
Do you have any of the following? • **Active implanted medical device**	**Yes** ☐	**No** ☐

• **Passive implanted medical device** • **Body worn medical device**		

Are you an expectant mother?	**Yes** ☐	**No** ☐	**Prefer not to say** ☐

APPLICANT'S DECLARATION

I declare that, to the best of my knowledge, all answers and statements I have given are true.

I understand that Reed may pass information contained within this form to their appointed third party Occupational Health Company for the purpose of additional screening. I hereby consent to Reed passing such information (together with any related documentation) to such organisations and for this information to be used and retained by them for the above purposes.

Signature:		**Print name:**	
Date:			