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| **AXIS HEALTH CARE**1 Cleeve CrescentBletchley Milton KeynesMK3 6LL**TEL**: 0330 330 2820Web: www.axishealthcare.co.ukEmail:admin@axishealthcare.co.uk | **for office use only****Deadline:** **Date Sent:****Date Returned:** |

**Staff Declaration of Health**

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| **The contents of this form will remain confidential and will not be disclosed to anyone without your written consent.** |
| **1. Personal Details** |
| **Surname:** | **Forename(s):** |
| **Any other surnames you have had:** | **Male/Female:** |
| **Title: Mr / Mrs / Miss / Ms / Doctor / Professor** | **Date of Birth:** |
| **Address:** |
|  **Post Code:** |
| **Contact Details:** |
| **Home:** | **Mobile:** |
| **Work:** | **Email:** |
| **2. Position applied for -**  |
| **Title of the position you have applied for:** |
| **This job may involve: - Please tick all that apply** |
| **Handling Service Users** 􀂈 **Working with human blood, tissues, fluids** 􀂈 **Working Night Shifts**  􀂈 **Handling heavy goods**  􀂈 **Using mobility equipment, hoists** 􀂈 **Driving**  􀂈 **Food Handling**  􀂈 **Regular VDU usage**  􀂈  |
| **For night shift workers:**How long have you been working nights?What type of work? | **For night shift workers:**Have you suffered any health problems that are directly related to working night shifts? Please state: |
| **3. Work Related History** | **Yes** | **No** | **Please give details:** |
| Have you been absent from work or full time study due to ill health during the last 12 months? |  |  |  |
| Have you ever left or been denied a job on health grounds? |  |  |  |
| Have you ever been denied a driving license on health grounds? |  |  |  |
| Have you ever suffered from any work related health conditions? |  |  |  |
| Have you ever had an accidental sharps injury or exposure to blood/bodily fluids with broken skin or mucous membranes?If YES please state opposite:* Date of the incident
* Status of source if known
* Details of treatment given at time of injury
* Details of follow up blood test results/surveillance
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| **4. Health History:** |
| **Do you have or have you had in the past:** | **YES** | **NO** | **Please give details:** |
| Conditions of the lungs?Asthma/bronchitis/pleurisy/tuberculosis/other chest complaints/coughing up blood/shortness of breath? |  |  |  |
| Conditions of the heart?High blood pressure/heart attacks/angina? |  |  |  |
| Nervous system disorder?Blackouts/epilepsy/muscular weakness/paralysis? |  |  |  |
| Migraine or persistent headaches? |  |  |  |
| Conditions of the digestive system?Irritable bowel syndrome/liver complaints/jaundice/colitis/gastric/duodenal ulcer? |  |  |  |
| Conditions of the bones, joints and limbs?Arthritis/rheumatism/back problems/neck and shoulder problems/sciatica/upper limb disorder/tennis elbow/any other conditions? |  |  |  |
| Allergies?Including allergies to drugs, animals and pollens |  |  |  |
| Skin conditions?Eczema/dermatitis/psoriasis/recent infection/skin cancer? |  |  |  |
| Gland trouble?Diabetes/thyroid – overactive/underactive? |  |  |  |
| Eye conditions?Restricted vision/glaucoma/iritis/any other conditions |  |  |  |
| Ear conditions?Restricted hearing/tinnitus/ear infections? |  |  |  |
| Alcohol or drug problems?Problems related to alcohol or drug usage or dependency? |  |  |  |
| Mental illness and/or stress related problems?Nervous breakdown/mental fatigue/anxiety/depression/panic attacks/significant sleep disturbance/stress related problems/eating disorders/self harm/any other conditions? |  |  |  |
| Have you consulted a specialist or need any operations other than already stated? |  |  |  |
| Have you spent any time in hospital other than already stated? |  |  |  |
| Have you consulted your GP in the last 12 months? |  |  |  |
| Are you receiving medical treatment at the present time? |  |  |  |
| Do you take any regular medication? |  |  |  |
| Are you aware of having any disability that is covered bythe Disability Discrimination Act? |  |  |  |
| Have you any disabilities affecting sight, hearing, standing,sitting, walking, lifting, driving, stair climbing, use of the handsor ability to carry out any work indicated in section 2? |  |  |  |
| Have you been in contact with MRSA?If Yes – did you contact Occupational Health?Please detail the treatment you received and state whetheryou have been cleared.You are required to inform New Hope immediately should you come into contact with MRSA |  |  |  |
| Have you any other health issues that have not beenmentioned above or about which you would like to providefurther details? |  |  |  |
| **5. Vaccination History** |
| To reduce the need for further blood tests, please provide a laboratory report or certificates signed and dated for your GP/ Vaccinated Centre or Occupational Health Department as evidence of any of the immunisations you have had as listed below: |
| **Immunisation and Blood Tests** | **Dates and Results (attach evidence)** |
| Hepatitis B primary course |  |
| Hepatitis B booster (s) |  |
| Hepatitis B antibody blood test |  |
| Varicella (proof of immunity) |  |
| Diphtheria (proof of 10 yearly update/booster) |  |
| Poliomyelitis (proof of 10 yearly update/booster) |  |
| Tetanus (proof of 10 yearly update/booster) |  |
| Rubella (proof of immunity) |  |
| Measles (proof of immunity) |  |
| Mumps (proof of immunity) |  |
| TB skin test e.g. Heaf test |  |
| BCG (protection against TB) |  |
| HIV (negative result for exposure prone procedure) |  |
| Hepatitis C (negative result for exposure prone procedures) |  |
| Hepatitis B Surface Antigen (for exposure prone procedures) |  |
| **Clinical Staff - health care workers who perform exposure prone procedures must inform Occupational Health if they suspect or****know they are HIV positive.** |
| **DECLARATION FROM WORKER****I declare that the information give within this declaration of health is true and complete to the best of my knowledge. I understand and accept that I may be required to attend for an Occupational Health Assessment.****I understand and accept that further medical information may be requested from my doctor if considered necessary.** **I understand that making false statements or failure to declare health problems could lead to removal from the Agency’s register.****I agree to update this declaration of health on an annual basis.** |
| **PRINT NAME:** | **SIGNATURE:** | **DATE:** |
| **GENERAL PRACTITIONER DETAILS** |
| **GP Name:** |
| **Address:** |
|  |
|  **Post Code:** |