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| **AXIS HEALTH CARE**1 Cleeve Crescent  Bletchley  Milton Keynes  MK3 6LL  **TEL**: 0330 330 2820  Web: www.axishealthcare.co.uk  Email: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 | |  | |  |  | |
| **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 by  the Disability Discrimination Act? | |  | |  |  | |
| Have you any disabilities affecting sight, hearing, standing,  sitting, walking, lifting, driving, stair climbing, use of the hands  or 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 whether  you 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 been  mentioned above or about which you would like to provide  further 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:** | | | | | | |