

Occupational Health Department  
St Georges Healthcare NHS  
Blackshaw Road, LONDON  
SW17 0QT

**Fitness to Work Questionnaire – (Pre-employment)**

**Incomplete Information will delay your starting date.**

* Use **Block** Capitals in **Black** type please. All questions **must** be answered or your application will not be processed and your clearance delayed
* Please note that the form is not currently compatible with apple macs
* Once completed, save and email the completed questionnaire to [**Health.Questionnaire@stgeorges.nhs.uk**](mailto:Health.Questionnaire@stgeorges.nhs.uk)

|  |  |
| --- | --- |
| **Job Title:** | **Name of Employer:** |
| Click here to enter text. | Click here to enter text. |
| **Line Manager’s Name and Contact number:** | **Department:** |
| Click here to enter text. | Click here to enter text. |
| **Recruitment Officer’s name and contact number:** | **Work-place site:** |
| Click here to enter text. | Click here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Title:**Choose an item. | **Gender:** | **Male:** | **Female:** |
| **Surname:**Click here to enter text. | | | |
| **First Name(s):**Click here to enter text. | | | |
| **Previous Surname:**Click here to enter text. | | | |
| **Address:** Click here to enter text. | **Date Of Birth**Click here to enter a date. | | |
| **Home Tel:** Click here to enter text. | | |
| **Mobile Tel:**Click here to enter text. | | |
| **Work Tel:**Click here to enter text. | | |
| **Email:**Click here to enter text. | | |

|  |  |
| --- | --- |
| **GP Name:**Click here to enter text. | **GP Address:**  Click here to enter text. |
| **GP Tel No:**Click here to enter text. |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **RISKS IN YOUR JOB** | | | | | | | | | | |
| **Will your POST involve work with or exposure to (refer to your job description or check with your manager)** | | | | | | | | | | |
| Human/blood/tissues/fluid |  | Manual handling/lifting duties |  | Night Work |  | VDU work |  | Violence | |  |
| * If you are a night worker, you are entitled to regular health assessments and these can be arranged by contacting Occupational Health Department during your employment. | | | | | | | | | | |
| **Will you be a worker in one of these categories of work that involves Exposure Prone Procedures:** | | | | | | | | | | |
| (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). | | | | | | | | | | |
| * Clinical staff in A&E Department * Renal Dialysis * Midwife * Staff Bank – Doctor, Nurse, any theatre staff except administrative and porters | | | | * Surgeon * Any theatre staff except administrative and porters * Dental – Surgeon/Nurse/Hygenist * Interventional Cardiologist * Interventional Radiologist | | | | |  | |

You may be required to provide additional information or attend a fitness assessment to ensure that you are fit for all of the work requirements and competencies with all reasonable adjustments that are essential.

The data controller is St George’s Healthcare NHS Trust and all information is stored and processed in accordance with our entry in the Information Commissioner’s online Data Protection Register available on <http://www.ico.gov.uk/>**.**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | | | | | | | **Yes** | | **No** |
| **1.** | Do you have any medical condition which affects your normal day-to-day activities e.g. walking, lifting, reading, house work or continence? | | | | | | |  | |  |
| **2.** | Will you require any essential special aids/equipment/ software or adaptations to undertake this job?  If yes to either 1 and/or 2 please give full details on the next page | | | | | | |  | |  |
| **3.** | **Please indicate whether you are fit to do the following tasks/duties if they are an essential part of your proposed work (refer to your job description):**  If **no:** please give **full details** on the next page | | | | | | | | | |
|  |  | | | | | | **‘X’ for Yes** | | **Not Applicable** | |
| a | Required starting /finishing times, standard day-time shifts, night shifts/rotating shifts, late and early shifts, long shifts of more than 8 hours with standard rest periods | | | | | |  | |  | |
| b | Move patients using correct techniques, transport patients by wheel chair/bed/trolley, move equipment, stand, climb stairs or walk distances that may be required, do all procedures and attend to emergencies /resuscitation as essential to your job | | | | | |  | |  | |
| c | Ability to document at pace by typing/keyboard and writing, do calculations, multi task, and use work equipment competently. This includes difficulties associated with dyslexia, dyspraxia, dyscalculia or learning difficulties. | | | | | |  | |  | |
| d | Adequate hearing and ability to communicate effectively verbally and by telephone | | | | | |  | |  | |
| 4. | Are there any duties in your job description that you anticipate you will **not** be able to fulfil? If yes, please state: | | | | | | | | | |
|  | Click here to enter text. | | | | | | | | | |
| 5. | If you answer YES to any of the following, please give details on the next page | | | | | | **Yes** | | **No** | |
| a | **Musculoskeletal problems:**  Have you had any of the following for a musculoskeletal health problem: | | | | | |  | |  | |
|  | * A scan or a hospital appointment in the past two years? | | | | | |  | |  | |
|  | * Time off work or school for more than a week over the past one year? | | | | | |  | |  | |
|  | * Surgical treatment for spine or any joint/bone disorder (including childhood)? | | | | | |  | |  | |
|  | * Attendance to pain clinic, physiotherapy or pain relief injection within the past 2 years? | | | | | |  | |  | |
| b | **Mental health problems:**  Have you ever had **any of** the following in relation to **any** mental ill health | | | | | |  | |  | |
|  | * An appointment to see a psychiatrist, psychotherapist, psychologist or other mental health care professional? | | | | | |  | |  | |
|  | * Needed medication for more than 6 weeks? | | | | | |  | |  | |
|  | * An admission to hospital either voluntarily or under section? | | | | | |  | |  | |
|  | * Bi-polar illness, psychotic episode, schizophrenia, paranoia, obsessive compulsive disorder or personality disorder? | | | | | |  | |  | |
|  | * Self-harm, overdose or self-induced injury? | | | | | |  | |  | |
|  | * Dependence or addiction to alcohol, illicit substances/drugs or prescribed and ‘over the counter’ medication? | | | | | |  | |  | |
|  | * Eating disorder if active within past five years? | | | | | |  | |  | |
|  | * Depression, including post-natal depression and/or anxiety needing to see the General Practitioner in the past one year? | | | | | |  | |  | |
| c | Do you, or have you suffered from, skin problems affecting hands/arms/face or other exposed areas? | | | | | |  | |  | |
| d | Are you pregnant? (please inform your line manager if pregnant) | | | | | |  | |  | |
| e | Are you currently receiving any treatment or regular medication (other than oral contraceptives or hormone replacement therapy - HRT) supervised by a doctor / healthcare professional? | | | | | |  | |  | |
| f | **Communicable Diseases Screen:** | | | | | |  | |  | |
|  | * Do you suffer from chronic infection to Hepatitis B, Hepatitis C or HIV infection? | | | | | |  | |  | |
|  | * Do you have active symptoms of TB such as cough or fever for more than 3 weeks, blood in the phlegm, drenching night sweats, loss of weight with poor appetite? | | | | | |  | |  | |
|  | * Do you have Immunosuppression due to an illness or medication which means that you are unable to have live vaccines such as MMR, Chickenpox or BCG (TB)? | | | | | |  | |  | |
| g | Do you suffer from a medical condition which is not covered by this questionnaire but may impact on your ability to fulfil your job role? Please supply additional information on next page | | | | | |  | |  | |
| 6. | Please indicate the total number of days sick leave from work/study over the past 24 months: | | | | | | | | | |
|  | Number of Days | Click here to enter text. | Number of Episodes | Click here to enter text. | Reasons | Click here to enter text. | | | | |

|  |
| --- |
| Please give additional information as indicated on the previous page in the space below. Use extra page and attach it if required. This will minimise delay in processing your health clearance and may also avoid the need for an appointment. Give details of the main symptoms, diagnosis, details of investigations, treatment and current symptoms.  **Attach copies of relevant medical and assessment reports** (including dyslexia or workplace assessment reports). Please do not send original documents. |
| Click here to enter text. |

**Evidence of immunity or vaccination is MANDATORY to work at St George’s Healthcare NHS Trust for the following diseases. Health clearance will not be given without this information:**

1. Measles, Mumps, Rubella, Tuberculosis and Chickenpox

**You must complete the immunity questionnaire overleaf.**

**You must attend the Occupational Health Department on day one of your post if you cannot provide all the information**

**SCREENING FOR HIV, HEPATITIS B AND HEPATITIS C INFECTION**

ONLY FOR STAFF CARRYING OUT EXPOSURE PRONE PROCEDURES (EPP): Please see page 1 for the list of jobs that involve EPP work

Please submit a copy of the immunity screen for above infections carried out on an Identity Validated Sample (IVS) obtained in an NHS Occupational Health Department. If not, screening for the above will be carried out by the Occupational Health Department before starting and staff must attend with either their photo driving licence or passport to enable IVS screening.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **IMMUNISATION RECORD**   * Immunisation and vaccination details to be completed in detail. If you have not had a specific vaccine, please answer NO to the questions. **Please do not answer not applicable (N/A)** in the spaces. * Please scan or send copies of your vaccine history/results with this completed form. | | | | | | | | | | | | |
|  | | | | | | | | | | **Yes** | | **No** |
| Have you entered the UK after living abroad in the last 5 years? | | | | | | | | | |  | |  |
| If yes from which country?Click here to enter text. | | | | | | | | | | | | |
| Is this your first post in the NHS? | | | | | | | | | |  | |  |
| Have you been in healthcare training in the UK or working in the NHS continuously for the past 5 years? | | | | | | | | | |  | |  |
| **BCG vaccine** | | **Do you have a BCG scar?** | | | **Have you had a Heaf test or Mantoux test for TB?** | | | **What were the results of the Heaf/Mantoux?** | | | | |
| Yes: | No: | Yes: | No: | |  | | | Grade/Size: Click here to enter text. | | | | |
| Date: | Click here to enter a date. | Scar Size: | Click here to enter text.  mm | | Yes: | No: | | Date:Click here to enter a date. | | | | |
| Hepatitis B primary  Course | | Yes: | No: | | Dates of injections  Click here to enter text. | | | | | | | |
| Hepatitis B Booster(s) | | Yes: | No: | | Dates of injections  Click here to enter text. | | | | | | | |
| Hepatitis B Surface Antibody level | | Yes: | No: | | Date of test and result (miu/ml):  Click here to enter text. | | | | | | | |
| Hepatitis B Surface  Antigen (IVS) | | Yes: | No: | | Date of test and result:  Click here to enter text. | | | | | | | |
| Hepatitis C Antibody (IVS) | | Yes: | No: | | Date of test and result:  Click here to enter text. | | | | | | | |
| HIV Antibody (IVS)\* | | Yes: | No: | | Date of test and result:  Click here to enter text. | | | | | | | |
| Have you had chicken  pox / shingles? | | Yes: | No: | | Have you had a blood test for chicken pox / varicella/VZV? | | | | | | | |
|  | |  |  | | Yes: | | No: | | Date & result:  Click here to enter text. | | | |
| Have you had Chickenpox vaccine? | | | | Yes: | | No: | |
| If yes Date of 1st Dose | | | | Click here to enter a date. | | | |
| Date of 2nd Dose | | | | Click here to enter a date. | | | |
| **Have you had MMR**  **vaccinations?** | | Yes: | | No: | Exact Dates of combined MMR Vaccinations   1. Click here to enter a date. 2. Click here to enter a date. | | | | | | | |
| **Have you had a Rubella blood test?**  Yes  No  Date of Test Click here to enter a date.  Result: Click here to enter text. | | **Have you had a Measles blood test?**  Yes  No  Date of Test Click here to enter a date.  Result: Click here to enter text. | | | **Have you had a Mumps blood test?**  Yes  No  Date of Test Click here to enter a date.  Result: Click here to enter text. | | | | | | | |
| **Vaccination for Diphtheria**  **& Pertussis  (whooping cough)** | | **Dates of injections**  Click here to enter text. | | | Date of boosters: | | | | Click here to enter text. | | | |
| **Tetanus Primary Course** | | **Dates of injections**  Click here to enter text. | | | Tetanus Boosters: | | | | **Dates of injections**  Click here to enter text. | | | |
| **Polio Primary Course** | | **Dates of injections**  Click here to enter text. | | | Polio Boosters | | | | **Dates of injections**  Click here to enter text. | | | |

Occupational Health may contact you via your private email address or mobile phone as given on this form. If you do not want us to contact you by these methods, please tick this box

I agree to comply with the requirements of the Occupational Health Department for immunity screen and immunisations in line with Trust policies **on commencing work. I understand that refusal to comply may result in termination of my employment.**

I declare that all of the information provided is accurate to the best of my knowledge. I accept that any false statement or withholding of information may result in termination of my employment.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | Click here to enter text. | **Date:** | Click here to enter a date. |