SEQOHS
Safe Effective Quality Occupational Health Service

Flax HEALTHCARE Selfless Care

OCCUPATIONAL HEALTH MEDICAL QUESTIONNAIRE
(NEW STARTER CLINICAL FORM)

CONFIDENTIAL

Due to the nature of the role you have applied for, we need to carry out a complete a New Starter Health Questionnaire – even if you have been employed in UK Health Services before. The health of each candidate is considered individually and a decision regarding fitness to work in the prospective job role will be based on the functional effects of any underlying health condition, disability or impairment as well as health service requirements for fitness and immune status.

Before health clearance is given for employment you may be contacted by Flax Healthcare Ltd and may need to be seen by an Occupational Health Advisor or Physician with gained consent. We may recommend adjustments or assistance following an assessment to enable you to carry out your proposed duties safely and effectively. Recommendations to your employer will be guided by essential information regarding your health and the hazards and risks of your employment and with due reference to other relevant statutory requirements and professional practice. Our aim is to promote and maintain the health of all individuals in the workplace: Staff, Service Users and Third Parties.

YOUR PERSONAL DETAILS

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other (Please State)

Surname: First Name(s):

Home Address:

Post code:

GP Address:

Post code:

Daytime Phone Number: Mobile:

E-mail Address:

MEDICAL HISTORY (ALL Staff Groups MUST complete this section)

Do you have any illness/impairment/disability (physical or psychological) which may affect your work? Yes ☐ No ☐

Have you ever had any illness/impairment/disability which may have been caused or made worse by your work? Yes ☐ No ☐

Are you having, or waiting for treatment (including medication) or investigations at present? Yes ☐ No ☐

Do you think you may need any adjustments or assistance to help you to do the job? Yes ☐ No ☐

HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING?

methicillin resistant staphylococcus aureus (**MRSA**) Yes ☐ No ☐

clostridium difficile (**C-Diff**) Yes ☐ No ☐

ADDITIONAL INFORMATION

(If you have answered yes to any questions above please provide additional information below, including dates, treatment and details of condition) Failure to do so will result in the form being returned/rejected.

CHICKEN POX OR SHINGLES

Have you ever had Chicken Pox or Shingles Yes ☐ No ☐ Date:

BBV (BLOOD BORNE VIRUS)

Have you ever come into contact with any BBV's? Including Needle Stick Injuries? Yes ☐ No ☐

TUBERCULOSIS

Clinical diagnosis and management of Tuberculosis, and measures for its prevention and control (NICE 2016) Yes ☐ No ☐

Have you lived outside the UK or had an extended holiday outside the UK in the last year? Yes ☐ No ☐

If you answered YES to the above, please list all the countries that you have lived in or visited over the last year, including holidays and vacations. This MUST include duration of stay and dates or this form will be rejected.

Have you had a BCG vaccination in relation to Tuberculosis? Yes ☐ No ☐

If you answered yes, please state when? Date:

Do you have any of the following:

A cough which has lasted for more than 3 weeks	Yes ☐ No ☐
Unexplained weight loss	Yes ☐ No ☐
Unexplained fever	Yes ☐ No ☐
Have you had tuberculosis (TB) or been in recent contact with open TB	Yes ☐ No ☐

Additional Information

(If you have answered yes to any questions above please provide additional information below)

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IMMUNISATION HISTORY

Have you had any of the following immunisations

Triple vaccination as a child (Diptheria / Tetanus / Whooping cough)	Yes ☐ No ☐	Date:
Polio	Yes ☐ No ☐	Date:
Tetanus	Yes ☐ No ☐	Date:
Hepatitis B *(If Yes is ticked please give dates below)*	Yes ☐ No ☐	

Course:	1 ☐	2 ☐	3 ☐
Boosters:	1 ☐	2 ☐	3 ☐

PROOF OF IMMUNITY (Please send the following)

Varicella	You must provide a written statement to confirm that you have had chicken pox or shingles however we **strongly advise** that you provide serology test result showing varicella immunity
Tuberculosis	We require an occupational health/GP certificate of a positive scar or a record of a positive skin test result **(Do not Self Declare)**
Rubella, Measles & Mumps	Certificate of **"two"** MMR vaccinations or proof of a positive antibody for Rubella and Measles
Hepatitis B	You must provide a copy of the most recent pathology report showing titre levels of 100lu/l or above

EXPOSURE PRONE PROCEDURES

Will your role involve Exposure Prone Procedures Yes ☐ No ☐

PROOF OF IMMUNITY (Please send the following) **EPP CANDIDATES ONLY**

Hepatitis B Surface Antigen	Evidence of Hepatitis B Surface Antigen Test (Inc. 'e' antigen and DNA viral loads if applicable Report must be an identified validated sample. (IVS)
Hepatitis C	Evidence of a Hepatitis C antibody test (Inc. Hepatitis C RNA/PCR if applicable) Reports must be an identified validated sample. (IVS)
HIV	Evidence of a HIV I and II antibody test (Inc. DNA viral loads if applicable) Reports must be an identified validated sample. (IVS)

The General Data Protection Regulation (GDPR) (EU) 2016/679

All information supplied by you will be held in confidence by Flax Healthcare Ltd. Records will be retained electronically in accordance with best practice of 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 Flax Healthcare Ltd. Your personal data may be required to be seen by an Occupational Health Advisor or Physician. However, neither the document, nor its contents will shared with anyone - including Managers, Human Resource Advisors, GP, Specialists or Third Parties, without your explicit consent. You have the right of erasure (the right to be forgotten), withdrawal of consent and refusal of consent without being penalised. 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.

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DECLARATION

I will inform my employer if I am planning to or leave the UK for longer than a three-month period to enable a reassessment of my health to be conducted on my return. ☐

I declare that the answers to the above questions are true and complete to the best of my knowledge and belief. ☐

Name: Signature: Date: