

Pre-Placement Questionnaire

To ensure that you are not employed in areas for which you are medically unsuited and to safeguard the health of all employees, it is necessary for this Questionnaire to be completed. The Questionnaire is CONFIDENTIAL and only the notification of your fitness for employment will be sent to Personnel/ Senior Management

Important: Please complete all sections fully and sign declaration, consent and authorisation sections as indicated on Page 5.

Please return completed questionnaire in the confidential reply envelope provided.

Job Role

Job Specification

- | | | | | | |
|----------------------|--------------------------|-------------------------------|--------------------------|---------------------------------------|--------------------------|
| Shift work | <input type="checkbox"/> | Operating fork lift trucks | <input type="checkbox"/> | Use of vibrating tools | <input type="checkbox"/> |
| Regular night work | <input type="checkbox"/> | Working in confined spaces | <input type="checkbox"/> | Ability to hear audible warning signs | <input type="checkbox"/> |
| Irregular night work | <input type="checkbox"/> | Working in dusty environments | <input type="checkbox"/> | Driving LGV/ HGV | <input type="checkbox"/> |
| Manual Handling | <input type="checkbox"/> | Working in noisy environments | <input type="checkbox"/> | Driving a car as part of the job role | <input type="checkbox"/> |
| Physical exertion | <input type="checkbox"/> | Operating machinery | <input type="checkbox"/> | Use of VDU's | <input type="checkbox"/> |

Your Details

Surname	<input type="text"/>	Title	<input type="text"/>
First Name(s)	<input type="text"/>	Date of Birth	<input type="text"/>
Address	<input type="text"/>	Telephone	<input type="text"/>
Postcode	<input type="text"/>		

Your Doctors Details

Name of GP	<input type="text"/>	Telephone	<input type="text"/>
Address	<input type="text"/>		

Previous Jobs – please give details of your last 3 jobs

Employer	<input type="text"/>	Position	<input type="text"/>
Description of duties	<input type="text"/>	Years from - to	<input type="text"/>
Employer	<input type="text"/>	Position	<input type="text"/>
Description of duties	<input type="text"/>	Years from - to	<input type="text"/>
Employer	<input type="text"/>	Position	<input type="text"/>
Description of duties	<input type="text"/>	Years from - to	<input type="text"/>

Have you been told you suffer from any of the following?

	Yes	No	Dates		Yes	No	Dates
Vibration white finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Significant injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Noise induced deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Dermatitis / skin condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Work related upper limb disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Occupational lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Back / spine / joint disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Occupational Exposure Record – In your last (L) or previous (P) jobs, have you ever had repetitive exposure or high level exposure to any of the following? (please tick) If ticked yes to the last or previous jobs then please provide further information on Page 3.

Hazard	No	L	P		No	L	P
Dust (asbestos, silica, cement material etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Solvents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manual handling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vibration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemicals incl. isocyanates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oils / greases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ionising radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tar, creosote, bitumen, asphalt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High voltage electricity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methylene Chloride	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fumes, gases, vapours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biological Hazards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Medical History / Health Status – please use additional space on Page 4 to add details if required

1. Do you have any illness/impairment/disability (physical or psychological) which may affect your work?

Yes No

If **yes**, please give details below or on page 4.

2. Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?

Yes

No

If **yes**, please give details below or on page 4.

3. Are you having, or waiting for treatment (including medication) or investigations at present?

Yes

No

If **yes**, please give details below or on page 4.

4. Do you think you may need any adjustments or assistance to help you to do the job?

Yes

No

If **yes**, please give details below or on page 4.

Do you wear glasses?

Yes

No

Do you wear contact lenses

} If yes, do you wear them for:

Distance / driving

Yes

No

Reading / near

VDU work e.g. Computer

Are you colour-blind?

If yes, please give more information

Have sight in only one eye?

If yes, please give more information

Additional information (please use the space below, or continue on a separate sheet if required)

Why should I sign this?

The consent below is requested so the questionnaire can be reviewed and the outcome fed back to your employer. The result enables your employer to ensure that the health, safety and welfare of yourself and other employee's is safeguarded.

Will the results be used for any other purpose?

No, this questionnaire is returned to Rockingham Occupational Health Ltd and is only accessible by medical personnel. A report is made to the employer but this only recommends whether you are fit for employment, fit with restrictions, further information is required or you are unfit for the post applied for (brief comments explaining the decision may be made).

If it is considered necessary, the Doctor may request that he discusses the contents of your questionnaire in more detail either by requesting a consultation in person or over the phone.

In certain circumstances, further information about any relevant medical conditions may be required from your doctor or other health professionals involved in your care. If this is necessary, your written consent will be requested and the workings of the Access to Medical Records Act 1988 explained.

DECLARATION

I declare that the information I have provided about my health is, to the best of my knowledge and belief, true and complete. I understand that not disclosing information may prejudice any subsequent entitlement to sick pay benefits, pension or life assurance eligibility.

I understand that if any recommendations to my employer are necessary as a result of this assessment, the Occupational Health Doctor will discuss the recommendations with me before making them to my employer.

*I give consent for the Occupational Health Advisor to make recommendations to my employer, without me having seen a written copy of the recommendations first.

OR

*I would like to see a written copy of any recommendations the Occupational Health Advisor may make to my employer before they are sent to my employer.

** delete one of the above statements before signing below.*

Signature Date

For Occupational Health Use Only -

Fit for work

Further Information required

Fit with restrictions

Unfit

Comments

Signature of Doctor

Date