**Health Questionnaire**

**Section 1:** To be completed by school/academy:

**Work role/Job Title: Dept/Area:**

**School/Academy: Hours per week:**

Send/give this form to the successful applicant:

* If the applicant ticks box **2 - No** to the declaration on page 2, they are deemed to be fit for the proposed employment. This form should be then retained on central employee personnel files.
* If the applicant has ticked **1 - YES** to the declaration on page 2, they will be sent an Employment Questionnaire and will be asked to complete and return it directly to Carlyon Bay Occupational Health. Occupational Health will undertake a more detailed assessment, the result of which should be obtained before employment commences.

**Section 2** - To be completed by the prospective employee:

Please complete and return this form to xxxx at the School or Academy which is offering you employment as soon as possible and **before starting your employment.**

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| --- |
| Name: |
| Address: | Date of Birth: |
| Home Tel No: |
| Mobile /Contact No: |
| Postcode: | Email Address: |

Your appointment is subject to an assessment of your fitness for work. The purpose of this is to identify any health problems or disabilities that may make the proposed job difficult or unsafe for you or others, and to enable your prospective employer to assess what adjustments to the job may be needed to enable you to work if you have a health problem or a disability.

**PLEASE READ THE QUESTIONS OVERLEAF CAREFULLY, THEN TICK WHICHEVER OF THE TWO STATEMENTS IS APPROPRIATE FOR YOU AND THEN SIGN THE DECLARATION.**

NOTE – To preserve medical confidentiality, please DO NOT identify any condition or illness you may or may not have, as this form is processed by neo:pm and your employer. A further form will be sent to you if you tick the YES box, which will require you to provide more detailed information and to be assessed in confidence by an Occupational Health Practitioner.

Do you have any condition that could affect your ability to undertake any of the activities of the proposed post, including shift patterns, without adjustments?

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

Has your work (hours or duties) ever been modified or have you had to leave a job because of a health problem?

Have you ever been affected by one of the following health problems:

1. Insulin dependent diabetes?
2. Epilepsy?
3. Musculoskeletal problems or back pain leading to more than two weeks absence or requiring treatment other than simple over-the-counter painkillers?
4. Skin disorders, eg: hand eczema?
5. Chest problems, eg: asthma?
6. Heart, circulation or blood pressure problems?
7. Impairments of vision (other than to wear glasses)?
8. Impairment of hearing?
9. Depression, psychiatric or nervous/stress problems; substance or alcohol misuse?
10. Any other problem that you may wish to bring to the attention of Occupational Health?

 **DECLARATION (please tick as appropriate)**

1. I would answer YES to one or more of the above questions.

2. None of the above applies to me.

NOTE: If you have ticked YES, a detailed health questionnaire will be sent to you for completion and return to the School’s Occupational Health Advisor. This will ask for further details of any medical condition(s), and will be held by Occupational Health staff in accordance with medical confidentiality.

**IMPORTANT** - in signing this questionnaire you confirm that all the information provided is true to the best of your knowledge. If it is subsequently shown that medical information has not been disclosed by you, or has been misleading or false, the offer of employment may be withdrawn, or you may be subject to disciplinary proceedings, which could result in dismissal.

I certify that, to the best of my knowledge and belief, the information given here is true and correct.

I undertake to submit, if required, to a further assessment including a medical examination and/or investigation by the School/Academy’s Occupational Health Provider.

|  |  |
| --- | --- |
| SIGNED: | DATE: |

**PLEASE NOTE THAT ANY DELAY IN RETURNING THIS FORM MAY**

**DELAY YOUR START DATE WITH YOUR NEW EMPLOYER**