Employee Health Declaration

Confidential

Care1 Professional Services LTD (CPSL) values the health and safety of its staff at work and has an obligation to insure this, pursuant to the Health and Safety at Work Act 1974. Hence, the purpose of this questionnaire is to determine whether you have any health issues that could potentially affect your ability to carry out your duties of the position that we have offered you or put you at risk in the workplace. We might recommend modifications or support depending on the results of this valuation to allow you to perform your duties. Before a health clearance is issued for employment you might be contacted by our Occupational Health Nurse if necessary.

By filling in this form, I am giving my consent for the health information contained herein to be processed in line with the requirements of the Data Protection Act, and agree that, if necessary, CPSL will share this information with its clients. Please complete all sections of this form that are applicable to you and should you require any clarification or further information contact CPSL Recruitment Team. Without the completed declaration form your registration will not be progressed.

Personal Details	
Surname:…….....	Male **[ ]** Female **[ ]**
First Name:……	
Date of Birth:…….....	
Job Role Applied for:.....	
Home Address:…….....**Postcode:**……..	**Telephone:**……..... **Mobile:**…… **Email:**…….....

Health Assessment Section - All staff complete this section

a) Do you have any health condition / impairment / disability (physical or psychological) which may affect your work? Yes **[ ]** No **[ ]**
If Yes, please give details with dates:

b) Are you having, or waiting for treatment (including medication) or investigation at present? Yes **[ ]** No **[ ]**
If Yes, please provide further details of the condition, treatment and dates:

c) Have you ever had any health condition / impairment / disability which may have been caused or made worse by your work? Yes **[ ]**No **[ ]**

If Yes, please give details with dates:

d) Do you think you may need any adjustments for assistance to help you to do the job?
Yes **[ ]**No **[ ]**

If Yes, please give details:

e) Have you had or are you suffering from any of the following symptoms; high temperature, severe headache, joint and muscle aches and pains, sore throat, vomiting, diarrhea, unexplained bleeding or bruising, lack of appetite? Yes **[ ]**No **[ ]**

If Yes to any of the above, please give details:

Tuberculosis (TB)

f) Have you lived or gone on holiday outside the UK within the last 5 years for 1 month or more?
Yes **[ ]**No **[ ]**

If Yes, please list all the countries where you have lived or gone to on holiday for a month or more over the past 5 years including the dates:

g) Have you had tuberculosis (TB) or been in recent contact with open TB? Yes **[ ]**No **[ ]**

If Yes, please give details:

Immunization Assessment Section - All staff complete this section

h) Have you had the following immunizations?

Rubella, Measles & Mumps	Yes **[ ]**No **[ ]**
Varicella (Chicken Pox)	Yes **[ ]**No **[ ]**
Tuberculosis (TB) BGC Scar	Yes **[ ]**No **[ ]**
Hepatitis B	Yes **[ ]**No **[ ]**

If Yes for Hepatitis – Give dates/approximate dates

1st Dose:…… 3rd Dose:……

2nd Dose:…… Booster:……

If Yes for the above-mentioned immunizations, please attached copy of the report

All Exposure Prone Procedures (EPP) Workers

EPP staff includes all surgeons, dental staff, theatre staff, midwives, A&E doctors and nurses. Note that general nursing duties, health care assistants or support workers are not considered EPP workers.

i) Are you applying to register with CPSL for an **Exposure Prone Procedures (EPP)** role?

Yes **[ ]** No **[ ]**

If Yes, please provide proof of immunity for the following as detailed below:

Hepatitis C	Evidence of negative Antibodies Test
Hepatitis B Surface Antigen	Evidence of negative Surface Antigen Test
HIV Aids	Evidence of negative Antibodies Test

Declaration

I hereby declare that all medical information given in this document is true and accurate to the best of my knowledge. I understand that if any information is incorrect, false, or if there is any omission it could result in disciplinary action being taken including termination of my registration with CPSL. Print your name below when you have read understood and accepted this declaration.

Name:…….....Date:……

Signature:……..

Please return your completed Health Declaration Form together with copies of documents as requested to:

Care1 Professional Services LTD
457 Valence Ave
Dagenham
Essex
RM8 3RB