



DECLARATION OF HEALTH AND HEALTH ASSESSMENT FORM
 (Failure to complete all sections may delay process of application)

PRIVATE & CONFIDENTIAL

SECTION A - TO BE COMPLETED BY APPLICANT

Position Applied For: _____

Surname: _____ Forenames: _____

Home telephone number _____ Mobile Telephone Number _____

Date of Birth: ____/____/____ Gender: Male / Female (please circle)

Address: _____

_____ Post Code: _____

GP's name: _____

_____ Post Code: _____

Height: Centimetres: _____ Feet: _____ Inches: _____

Weight: Kilograms: _____ Stones: _____ Pounds: _____

(Tick as applicable)

YES NO

Have you ever been deemed medically unfit for any reason? YES NO

Are you, or have you ever been, in receipt of a disability Pension? YES NO

Are you registered under the Disabled Persons (Employment Act 1944)? YES NO

If "YES" – Expiry Date: ____/____/____

Have you ever attended hospital for illness, operations, or injury? Yes No If "YES", please give details below:

Date	Nature of illness, operation or injury	Hospital Name & Address
/ /		
/ /		
/ /		
/ /		

Have you ever suffered from, or are you now suffering from any of the following? Yes No

If "YES", please tick those applicable below:

	YES	NO
A Rheumatic fever?		
B Bronchitis or pleurisy?		
C Heart disease or circulatory problems?		
D Coughing of blood?		
E Tuberculosis?		
F Asthma, hay fever or allergy?		
G Epilepsy, fits, faints or seizures?		
H Migraine or severe headaches?		
I Mental illness, e.g. depression, bipolar disorder, breakdown etc.?		
J Any disease of the bladder or kidneys?		
K Stomach (ulcer), bowel, or any abdominal disorder or rupture?		
L Severe sprain, upper limb disorder or other injury?		
M Any skin disease?		
N Any severe reaction to drugs or injections, e.g. Penicillin or Tetanus?		
O Any eye trouble, squint or need for glasses?		
P Any condition preventing full use of limbs and joints?		
Q Any foot disorder which prevents you being on your feet for the majority of the working day?		
R Varicose veins?		
S Any back, neck or spinal trouble?		
T Have you ever had a chest x-ray (If "YES" please give dates and details below)		
U Are you presently receiving treatment of any kind for any kind of condition?		
V Are you taking any medication?		
W Any sleep disorders?		

If you have ticked "YES" to any of the above please give further details below:

(Please note that our Manager of Nursing Services will undertake a risk assessment on any condition(s) and dependent upon the result may decide to obtain further information and advice from your doctor)

PLEASE GIVE LAST DATES OF THE FOLLOWING IMMUNISATIONS AND VACCINATIONS:-

Date of immunisation/vaccination:

{	Diphtheria	_____ / _____ / _____	}
	Poliomyelitis	_____ / _____ / _____	
	Tetanus	_____ / _____ / _____	
	Mantoux Heaf or Tyne test	_____ / _____ / _____	
	Hepatitis B	_____ / _____ / _____	
	Rubella (German measles)	_____ / _____ / _____	
	Varicella (Chicken Pox)	_____ / _____ / _____	
Tuberculosis (BCG)	_____ / _____ / _____		

Note - Please enter, for example: "In Childhood",
"In Adulthood", etc. if exact dates are unknown.

Immune? Yes No

Immune? Yes No

Immune? Yes No

For office use: Scar evident? YES / NO

Please insert below your sickness / absence from work record for the last 3 years starting with the last 12 month period

Period	Total number of days	Number of occasions	Nature of sickness / absence
Last 12 months			
Previous 12 months			
Previous 12 months			

YES NO

Have you previously worked during the night?

If "YES" did you experience any health problems as a result?

If you answered "YES" to the above, please give details below:

You are responsible for the accuracy of this declaration. Any false statement may invalidate your application or render you liable to dismissal.

I declare that the foregoing statements are true and complete to the best of my knowledge and belief and consent to the information contained in the assessment resulting from the completion of this questionnaire being made available to the appropriate Everycare Registered Nurse. I agree to attend medical examinations if required, and consent to your referral to an occupational health clinician, or consultation with my GP or any named hospital consultant about any condition.

Please Note:- Medical practitioners may make a charge for providing written evidence of immunisations and vaccinations. They normally levy a charge if in our Nurse Manager's sole opinion it is advisable to obtain their written opinion on a particular condition. In either circumstance the Applicant accepts that they shall be liable for paying all such charges, either directly to the medical practitioner, or forthwith on presentation of the medical practitioners account by Everycare. Such payments will not be refundable if for any reason an application for employment is unsuccessful.

Signature of applicant _____

Date ____/____/____

SECTION B – FOR OFFICE USE ONLY

PRE-SCREENING ASSESSMENT BY REGISTERED NURSE:

No further action Refer to Occupational Health Nurse Refer to Medical Practitioner for advice

Name of Registered Nurse: _____ Signature of Registered Nurse: _____

Date: ____/____/____

ASSESSMENT BY OCCUPATIONAL HEALTH NURSE:

No further action Refer to Medical Practitioner for advice

Name of Occupational Health Nurse: _____ Signature of OH Nurse: _____

Date: ____/____/____

MEDICAL PRACTITIONERS ADVICE:

Name of Medical Practitioner: _____ Signature of Medical Practitioner: _____

Date: ____/____/____

EVERYCARE MANAGER

Having viewed the above Health Declaration report, and following interview on a one-to-one basis, I consider this applicant to be physically and mentally fit for the purposes of the work which they are to perform.

Name of Everycare Manager: _____ Signature of Manager: _____

Date: ____/____/____