ORKNEY
ISLANDS COUNCIL

PRE-EMPLOYMENT HEALTH QUESTIONNAIRE

Section A: This section to be completed before sending out to the candidate.

Candidate Name			
Telephone Number		**E-mail address**	

Post Applied Form	
Service	
Work Location	

Is this application in respect of a Orkney College Student to undertake a work placement as part of their course. **YES / NO**

Job Tasks (please indicate if any of the specific tasks are applicable to this post)

Task	**Relevant** (please tick)	**Task**	**Relevant** (please tick)
Driving (Car/Van)		Exposure to Excessive noise	
Driving (HGV/PCV)		Use of vibrating tools	
Display screen use		Contact with skin irritants	
Food handling		Contact with lung irritants	
Lone working		Work involving strenuous effort	
Shift working		Working at height	
Night working		Working in static and/or awkward positions	
Working with people requiring physical assistance		Working in confined spaces	
Working with people with challenging behaviour		Sea going post	
Working with vulnerable adults		Wearing breathing apparatus	
Working with children		Working in close proximity to traffic	
Administration of prescribed medication		Other (please specify)	

Section B: This section to be completed by the job applicant.

Please read the following before completing the questionnaire:

- This form will be used by Occupational Health to assess your capability for employment (including safety aspects), to identify any disabilities that may affect safety or work performance, and to advise the Council about reasonable adjustments if necessary.
- The information provided by you will be treated in strict medical confidence and in accordance with the Data Protection Act 1998.
- If medical reports are required from your GP or specialist this will only be obtained with your written consent.
- In signing the declaration at the end of this questionnaire you are confirming that all the information provided is true to the best of your knowledge. You also accept that in the event of being employed, and it is subsequently shown that relevant medical information has not been disclosed by you, or is deliberately misleading or false, then you may be subject to Orkney Islands Council's disciplinary process.
- Please complete all questions; failure to complete all sections may result in a delay in the confirmation of your employment.

Personal Details

Surname		**Date of Birth**		**Sex**	Male / Female
Forename(s)					
Address					
Telephone (Home)		**Telephone Work or Mobile**			

Your Family Doctor

Doctors Name	
Doctors Address	

Previous Employment (continue on separate sheet if necessary)

Start Date	Employer	Job	End Date	Was health a factor in leaving this post?
				YES / NO
				YES / NO
				YES / NO
				YES / NO
				YES / NO
				YES / NO

Exposure to Hazards - have you been exposed to any of the following hazards in any previous job? (please provide details for all 'yes' answers at the end)

Hazard	Exposure	Exposure over what Period of Time	Developed a medical condition as a result of exposure?
Noise	YES / NO		YES / NO
Vibration	YES / NO		YES / NO
Dust	YES / NO		YES / NO
Chemicals	YES / NO		YES / NO
Lead	YES / NO		YES / NO
Radiation	YES / NO		YES / NO
Physically demanding work	YES / NO		YES / NO
Other (please specify)	YES / NO		YES / NO

Medical History (please provide details for all 'yes' answers)

1	Have you ever been refused a job on health/medical grounds?	YES	NO	
2	Have you been advised against carrying out any practical type of work on health/medical grounds?	YES	NO	
3	Have you had to give up a job for health /medical reasons?	YES	NO	
4	Have you had an illness or accident in the past, which caused you to be in hospital?	YES	NO	
5	Have you been absent for work for more than 10 days in the last 12 months and/or 3 times in the last 6 months?	YES	NO	
6	Are you currently on any prescribed medication (excluding the contraceptive pill)?	YES	NO	
7	Have you consulted your own doctor or any other health practitioner during the last 12 months?	YES	NO	

Do you now, or have you ever suffered from:

8	Eye disease or visual problems including impaired colour vision?	YES	NO	
9	Disabling headaches or migraine?	YES	NO	
10	Ear disease or hearing problems? (answer 10a if Yes)	YES	NO	
10a	Do you wear a hearing aid?	YES	NO	
11	Stomach or bowel problems (e.g. diarrhea or indigestion)	YES	NO	
12	Jaundice or Hepatitis or other liver problem?	YES	NO	
13	Hernia (rupture)?	YES	NO	
14	Heart disease, high/low blood pressure or Stroke?	YES	NO	
15	Asthma, Tuberculosis or other chest problems?	YES	NO	
16	Kidney disease or bladder complaint?	YES	NO	
17	Epilepsy, fainting, dizziness or loss of consciousness?	YES	NO	
18	Any nervous system disorder (such as Multiple Sclerosis or Parkinson's disease)?	YES	NO	
19	Any form of brain tumor, brain or head surgery?	YES	NO	
20	Any serious head injury with or without skull fracture?	YES	NO	
21	Sleep apnoea, or narcolepsy?	YES	NO	
22	Diabetes?	YES	NO	
23	Any skin problem (e.g. eczema, dermatitis) or recurrent infections?	YES	NO	
24	Allergies (to drugs or any other substance) or hay fever?	YES	NO	

25	Any problems with lifting, pushing/pulling, carrying, bending down, crouching or kneeling?	YES	NO	
26	Any problems with prolonged or repeated kneeling or crouching?	YES	NO	
27	Any problems raising arms above shoulder height?	YES	NO	
28	Any problems with backache or neck ache?	YES	NO	
29	Any time off work for back or neck ache or aches/pains in other joints?	YES	NO	
30	Any problems with your hips or knees?	YES	NO	
31	Any problems with your shoulders or elbows (including tennis elbow)?	YES	NO	
32	Any problems with any other joints or muscles e.g. wrists, hands, ankles, feet or weak thighs?	YES	NO	
33	Any bone fractures, joint dislocation, or any surgery to muscles, joints or spine? Include any artificial joints or metal plates.	YES	NO	
34	Treatment for any muscle of joint disorder?	YES	NO	
35	Treatment or support from a psychiatrist, psychologist or counselor?	YES	NO	
36	Treatment for anxiety, depression, stress, schizophrenia or any other mental health disorder?	YES	NO	
37	Have you ever had any alcohol, drug (including prescription medication) problems?	YES	NO	
38	Any form of cancer or abdominal growths?	YES	NO	
39	Any form of work related injury or illness?	YES	NO	
40	Any health problems related to shift working? e.g. depression, bowel symptoms or sleep disorder?	YES	NO	

41	Any other medical condition, which in your opinion could be aggravated by shift working?	YES	NO	
42	Any medical condition which could incapacitate you at work e.g. epilepsy, severe migraine, severe asthma, vertigo, blackouts?	YES	NO	
43	Dyslexia or reading or writing difficulties?	YES	NO	
44	Do you drink alcohol? If Yes, how many units per week? (1 unit = ½ pint of beer or 1 pub measure of spirits or 1 small glass of wine)	YES	NO	
45	Do you smoke? If Yes, what and how much per week?	YES	NO	
46	Given the tasks, duties and responsibilities of this post do you have any concerns about your physical or mental health in undertaking these?	YES	NO	

Other Information - Please provide any other information in relation to your physical and/or mental health which you wish Occupational Health to take into consideration. Continue on a separate sheet where necessary.

DECLARATION BY APPLICANT

I certify that to the best of my knowledge and belief the above answers are true and complete. I understand that medical information gained from this questionnaire will remain confidential but will be used by Occupational Health to advise Orkney Islands Council about my fitness to undertake the duties of the employment for which I have applied and I consent to this use being made of the information.

I understand that now and, if employed by the Council, in the future, I have a duty to report any health condition or medication which could affect safety, concentration or performance at work.

I accept that in the event of being employed, and it is subsequently shown that relevant medical information has not been disclosed by me, or is deliberately misleading or false, then I may be subject to Orkney Islands Council's disciplinary process.

Signature (Applicant):_____ **Date:** _____

Please return the completed questionnaire in the envelope provided

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Certificate of Fitness for Employment

Name of Individual:

Date of Birth:

Position Applied for:

Having reviewed the information provided in the pre-employment health questionnaire and if considered medically necessary carried out a pre-employment consultation with the above named individual, I would confirm that I consider that they (please tick 1 box):

☐ **are fit to undertake the above employment, without restrictions or adjustments.**

☐ **may be fit to undertake the above employment, with the restrictions or adjustments as outlined below.**

☐ **are unfit to undertake the above employment.**

Recommended Restrictions and/or Adjustments

Signature _____ **Date:** _____

Occupational Health Physician

Please complete and return this certificate to:

HR Support, Orkney Islands Council, School Place, Kirkwall, Orkney KW15 1NY or via email to hrsupport@orkney.gcsx.gov.uk