The Occupational Health Service
Hinchingbrooke Health Care NHS Trust

SOLO
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CONFIDENTIAL
HEALTH DECLARATION FORM

To all Applicants,
Your appointment is subject to satisfactory health clearance, which requires you to complete this form. Information given to us about your health will be treated in the strictest confidence. Your answers to this questionnaire will help us to ensure that the work you are planning to do will not place your health at risk. You are required to declare at the end of the questionnaire that all your answers are correct to the best of your knowledge. You should be aware that if you leave anything out intentionally or answer untruthfully your appointment may be affected. Should there be any concerns about your health and the proposed job, a member of The Occupational Health Service may contact you for further information and you may be required to attend a clinical assessment.
If you have any questions about completing this form please contact a Nurse Advisor on Tel: 01480 416263

PERSONAL DETAILS
Please use Block Capitals

Position applied for______________________________________ Full time/Part time/Shift Work/Night Work

SURNAME_________________________________ MR/MRS/MISS/MS/DR _______________________

FIRST NAMES __________________________________ DATE OF BIRTH __________________________

ADDRESS____

____ POST CODE ______________ TEL NO ______________

DOCTOR'S NAME AND ADDRESS____

____ TEL NO ______________

HEIGHT (Without shoes) __________________ MTRS/FT. IN WEIGHT ST/LB/KG _______________

PREVIOUS EMPLOYMENT DETAILS
Please list your employment details for the past 10 yrs starting with your present employment.

DATES: FROM	TO	JOB DESCRIPTION

During the past 2 years **how many occasions** have you taken sick leave from work, training or education? Occasions	Approximately how many days in total does this amount to? Days

MEDICAL HISTORY

DO YOU SUFFER FROM, OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING:	YES	NO	(IF YES PLEASE GIVE FULL DETAILS INCLUDING DATES).
Do you have a disability, which may require adaptation of work, the workplace or work schedule?			
Mental disorder, depression, anxiety, nervous breakdown or any other nervous disorder.?			
Psychiatric illness requiring any in-patient or out - patient treatment?			
Dependence on drugs or alcohol?			

MEDICAL HISTORY continued

DO YOU SUFFER FROM, OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING:	YES	NO	(IF YES PLEASE GIVE FULL DETAILS INCLUDING DATES).
Vertigo (dizziness) fits after the age of 5 years or fainting attacks, blackouts, epilepsy.?			
Back, neck or joint troubles (e.g. slipped disc, lumbago, sciatica, arthritis rheumatism etc.)?			
Any pain or discomfort at any time in hands, wrists, arms or shoulders?			
Chest trouble, breathing difficulties, asthma, recurrent bronchitis or pneumonia?			
Hay fever or allergy to anything?			
Heart, circulation or blood pressure problems?			
Skin trouble (dermatitis, eczema, psoriasis)?STATE PART OF BODY AFFECTED			
Eye trouble or vision defect			
Persistent ear trouble or hearing defect? (Discharge or infection of the ears or hearing defect)			
Kidney or bladder trouble?			
Hepatitis, liver complaint or yellow jaundice?			
Persistent indigestion, stomach or duodenal ulcer, gall bladder disease or bowel problems?			
Persistent/recurrent attacks of diarrhoea/vomiting/ abdominal pain?			
Recent unexplained weight loss?			
Diabetes, thyroid or gland trouble.			
Any other serious illness, major surgery or severe injury.			
Migraines or persistent headaches			
Have you ever retired on medical grounds from any form of employment?			
Do you have a disability? If so, do you have any special requirements?			
Are you currently taking any medicine or undergoing any course of treatment prescribed by your doctor or a hospital specialist?			

NIGHT WORKERS HEALTH ASSESSMENT

Do you have any health problems (including medical conditions affecting sleep), which may affect your ability to perform night work?			

I certify that the answers to the aforementioned questions are correct to the best of my knowledge? I give consent to be examined if necessary. I am aware that failure to make a full declaration of health may lead to dismissal. I understand that no medical details will be divulged without my permission to any person outside the Occupational Health Service, but an opinion about my fitness for work will be given to the Appointing Officer.

SIGNED ______________________________ DATE ______________________________

FOR OFFICE USE ONLY

Fit for Post ❐ H. I with NA ❐ H.I. with Dr ❐ Signed ______________________________

Date Clearance sent ______________________________ Signed ______________________________