

Work Health Assessment

Fire & Rescue Service (NON-UNIFORMED)

This form should be used to provide an overview of the health of a potential or existing employee who is seeking to take on a new role within the organisation. This information is used to make an assessment of an individual's health and their ability to fulfil the duties of the role they have been offered; therefore it is essential that the information provided is accurate and complete.

- The applicant should complete the entire form, answering all questions, and return the completed form using our online system, or if this is not possible, by using the details below.

Delays in returning this form may lead to delays in confirming your appointment.

For assistance with this form or the process for which this form is part, or to submit the completed form, please contact;

Team Prevent, Warwickshire County Council, Shire Hall, Warwick CV34 2AJ.

Email: teamprevent@warwickshire.gov.uk, Tel.: 01926 418125.

FOR OFFICE USE ONLY				
Outcome of OH Review	<input type="checkbox"/> Fit	<input type="checkbox"/> Fit with Adjustments*	<input type="checkbox"/> Not Fit	* if appropriate please outline adjustments above

Position Details

Job Title			
Team /Location			
Directorate	Fire & Rescue Service		
JEID Number*		*applicable for all single status positions	

Personal Details

Forename(s)				
Surname			Title (e.g. Mr, Mrs)	
Address				
Town / City		Postcode		
Telephone Number		E-mail Address		
Date of Birth		Are you a current employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please provide your Employee Number				
If NO, please provide your National Insurance Number				

Health History

Please answer ALL questions to provide a detailed understanding of your health and wellbeing, thereby allowing a full assessment of your fitness to work. This forms part of any conditional offer of employment; therefore it is essential that the information provided is accurate and complete.

Health Details

Please outline below any of your previous jobs / occupations (including your job title and employment dates) that may have caused health problems.

Are you on a hospital waiting list for investigation or treatment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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Are you regularly attending hospital, community clinic or seeing a doctor?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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When did you last see your GP?		
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What was the reason for your visit?	
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Are you taking any tablets or medication at present?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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If YES, please provide details of below;

Have you ever retired from a job for medical reasons?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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Are you currently employed by Warwickshire County Council?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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If YES, please provide details of your job title, directorate and start date below;

If NO, have you ever been employed by Warwickshire County Council?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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If YES, please provide details of your job title, directorate and start date below;

Have you ever had a pre-employment assessment / medical?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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If YES, please provide details of when and where below;

Medical Questionnaire

Please ensure that all questions are answered. It should be noted that a positive answer to any question does not automatically bar an applicant from consideration for employment.

Are you suffering from or have you ever suffered from any of the following?		
Any conditions relating to your heart (e.g. angina, chest pains, palpitations)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any circulatory conditions (e.g. high or low blood pressure)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any respiratory or chest problems (e.g. bronchitis, pneumonia, asthma or frequent chest infections)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
A cough that lasted for over three weeks in the last year	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Situations where blood was coughed up	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any psychological problems (e.g. nervous breakdown / depression / anxiety or stress related illness)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any eyesight condition that cannot be corrected by wearing spectacles or contact lenses	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any ongoing hearing problems or ear disorders (e.g. deafness, tinnitus or the need to wear a hearing aid)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any recurrent ear infections	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any eye problems or eye disease, do you wear spectacles or contact lenses, do you have monocular or tunnel vision?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any back problems (e.g. backache, back injury, recurrent back pains or disc problems)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any problems or difficulties in bending, lifting, sitting or standing for long periods?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any tendon problems (e.g. tenosynovitis, carpal tunnel or 'tennis elbow'?)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any other joint problems (e.g. rheumatism, arthritis)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any restriction in movement of the neck, back arms, legs or hands?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any skin diseases, complaints or conditions that requires medical treatment (e.g. dermatitis, psoriasis, eczema)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any stomach or bowel problems (e.g. ulcer, diarrhoea, irritable bowel syndrome)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any gastro-intestinal or abdominal problems (e.g. Hernia, Gall Stones)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any gland disorders (e.g. diabetes, thyroid)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any blood disorders (e.g. anaemia, Hepatitis B)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any other form of hepatitis or jaundice	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any neurological conditions (e.g. vertigo, epilepsy, balance problems, fainting attacks or giddiness)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Migraines, severe or frequent headaches?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any long-term or debilitating illness (e.g. Multiple Sclerosis)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any condition relating to Hand Arm Vibration Syndrome (HAVS)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any drug or alcohol dependency problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Anorexia / bulimia or other eating disorder	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any other mental health problems / illnesses	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Unexplained weight loss, fever or night sweats in the last year	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Chest X-ray (do not have one unless requested to do so)	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Any known allergies (e.g. latex, drugs, chemicals, foods, or hayfever)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any other serious illness, infection, operation or injury not mentioned	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If you have answered YES to any of the above questions, please provide details below, indicating if you have been treated by your GP or hospital;		

Declaration

I certify that I have answered all the questions to the best of my ability and knowledge. If required, I understand that I may need to provide further details of anything disclosed in this questionnaire. I understand that withholding information or knowingly giving incorrect information about my health on this form may result in disciplinary action or dismissal. If deemed necessary, I consent to a medical interview / assessment and agree that Occupational Health will advise my employer about my fitness to work and if this presents a health and safety hazard to staff, or Council service users or myself.			
Signature		Date	

This form should NOT be returned to the Recruiting Manager or the Recruitment Centre, and will not be shared with the organisation at any stage. The entire completed form should instead be sent to Occupational Health using the details provided.