Work Health Assessment

Fire & Rescue Service (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 by post to Occupational Health using the details provided.

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, please contact;
Occupational Health, Service Headquarters, Warwickshire Fire & Rescue Service, Warwick Street, Leamington Spa, CV32 5LH.
Tel.: 01926 423231 (ext. 3268).

FOR OFFICE USE ONLY

Position Details

Job Title	
Team /Location	
Directorate	Fire & Rescue Service

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?	☐ Yes	☐ No	
If YES, please provide your Employee Number					
If NO, please provide your National Insurance Number					

This questionnaire will be used by Occupational Health to advise on your health suitability to undertake the duties of the post for which you have applied. These questions are asked in order to identify aspects of your health which may need further assessment in order to ensure that you are not put at risk of further health problems and that our Duty of Care (under the Health & Safety at Work Act) is met.

The information you provide will be stored and treated in strictest confidence by the Occupational Health staff according to the rules set out in the Data Protection Act (1998). In accordance with this Act you may have access to your records at any reasonable time. If you require a copy of any part of your record this will only be supplied following a written request. No clinical details will be disclosed without your written consent.

Section 1 - Medical Questionnaire

Are you suffering from or have you ever suffered from any of the following? Please answer all of the following questions.		
1. Eye problems including squint, cataracts, glaucoma, colour deficiency or undergone any medical or surgical procedure to correct vision?	☐ YES	☐ NO
2. Do you wear glasses / contact lenses?	☐ YES	☐ NO
3. Have you had corrective laser surgery to your eyes?	☐ YES	☐ NO
4. Recurrent ear infection, discharge or any hearing problems including tinnitus in either ear?	☐ YES	☐ NO
5. Persistent, recurrent sore throats, sinusitis or upper respiratory problem?	☐ YES	☐ NO
6. Asthma, bronchitis, pleurisy, TB or any other chest disease?	☐ YES	☐ NO
7. Heart disease, high blood pressure, chest pain, rheumatic fever or circulatory problems?	☐ YES	☐ NO
8. Varicose veins or other vascular disorder?	☐ YES	☐ NO
9. Blood disorders, e.g. Anaemia, leukaemia, sickle cell.	☐ YES	☐ NO
10. Digestive disorders, including gastric/peptic ulcers, inflammation of the bowel or bowel disorders?	☐ YES	☐ NO
11. Jaundice, hepatitis, other liver disorder?	☐ YES	☐ NO
12. Hernia (rupture)?	☐ YES	☐ NO
13. Cystitis, bladder or kidney disorder?	☐ YES	☐ NO
14. Epilepsy, blackouts, fainting, dizziness, vertigo or fits?	☐ YES	☐ NO
15. Migraine or recurring headache?	☐ YES	☐ NO
16. Stress, nervous debility, depression, anxiety or any other mental illness?	☐ YES	☐ NO
17. Bone or joint problems including disorder of the spine or limbs, fractures or injuries to the joints or tendons	☐ YES	☐ NO
18. Arthritis or rheumatism?	☐ YES	☐ NO
19. Difficulty in standing, bending, lifting or with any other movements?	☐ YES	☐ NO
20. Eczema, dermatitis, psoriasis or other skin conditions?	☐ YES	☐ NO
21. Allergies e.g. Pollen, dust chemicals or medicines?	☐ YES	☐ NO
22. Diabetes, thyroid trouble or any other endocrine disorder?	☐ YES	☐ NO
23. Malignant disease (cancer)?	☐ YES	☐ NO
24. Surgical treatment, investigations or admission to hospital?	☐ YES	☐ NO

25. Are you receiving or expecting to receive any treatment or investigations of any kind at the moment?	☐ YES	☐ NO
26. Are you taking any medication (prescribed or bought over the counter)?	☐ YES	☐ NO
27. Any other illness, disability or recurring problem not listed above?	☐ YES	☐ NO
28. Do you consider yourself to be disabled?	☐ YES	☐ NO
29. Have you ever been advised for medical reasons not to do night work, shift work or any other kind of work?	☐ YES	☐ NO
If you have answered YES to any of the above questions, please provide details below. Please include detail on; when you last had the problem, how long it lasted, the type of treatment you received, if you were admitted to hospital and if you were unable to work or prevented from carrying out your normal activities due to the problem, and if the condition continues to affect you in any way.		

Section 2 – Lifestyle Details

30. Do you smoke?	☐ YES	☐ NO		
If YES, how many cigarettes/ cigars do you smoke each day				
If NO, have you ever smoked?	☐ YES	☐ NO		
If you have smoked, when did you quit?				
31. How much alcohol do you drink per week				
32. Have you ever had a problem with drug, alcohol or other substance misuse?			☐ YES	☐ NO
If YES, please provide details of below;				
33. Please give details below of any regular sport / exercise do you do?				

Section 3 – Immunisation / Vaccination

If you have received any of the following immunisations / vaccinations, please provide the date you received them?			
Polio		Rubella (German Measles)	
Tetanus		BCG (TB injection)	
Hepatitis B			

Section 4 - Sickness History

Please outline below all your sickness absence history for the past 3 years, providing the dates, duration, and reason for each instance of leave (please continue on a separate sheet of paper if required).

Declaration

I declare that I have answered the questions on this form honestly and fully and that I am not otherwise aware of any physical or mental disability which will or may affect my working capacity before retirement age. I am aware that any false or incomplete statement may affect my appointment or future employment. I understand that all of the information given on this form will be treated in the strictest confidence and protected under the terms of the Data Protection Act 1998 and any subsequent legislation. I understand that suitability for employment statement only will be given to Human Resources and no clinical details provided without written consent.			
Signature		Date	

This form should NOT be returned to the Recruiting Manager or the Recruitment Centre, and will not be shared outside Occupational Health. The entire completed form should instead be sent to Occupational Health using the details below.

Application for Medical Records
Consent Form

It will be necessary for the Service Medical Advisor to obtain further information from your GP in order to determine fitness for employment. Any information provided will form part of your Occupational Health record and will remain confidential. Under the 'Access to Medical Reports Act 1988' this information cannot be provided without your consent. You have the following options regarding any report requested:

1. You may withhold your consent.
2. You may consent to the application, but indicate your wish to see the report before it is supplied. (You must make the necessary arrangements with the medical practitioner to see the report; it will not be sent to you automatically). When you see the report, if there is anything in it which you consider incorrect or misleading you can request in writing that the medical practitioner amend the report, but he/she is not obliged to do so. If the medical practitioner refuses to amend it you may:
   a) Withdraw your consent for the report to be issued.
   b) Ask the medical practitioner to attach to the report a statement setting out your own view.
   c) Agree to the report being issued unchanged.

   You may also withdraw consent to the report being provided if your General Practitioner declines to show you the report, or part of the report, if they consider there are special circumstances as described in the Act.
3. You may consent to the report being provided (and request a copy if you wish, up to 6 months after it has been provided.)

The Occupational Health department will inform you when the report has been requested.

Your Doctor's Details

GP Name			
Address		Postcode	
		Tel. No.	

GP Records Consent

Please select one of the following statements, that best determines your consent;	
I consent to a copy of my GP records being provided to the Occupational Health Department	☐
I consent to a full copy of my GP records being provided to the Occupational Health Department, but I wish to see it before it is issued.	☐
I do not consent to a full copy of my GP records being provided to the Occupational Health Department	☐

Declaration

Signature		Date	
Name		Date of Birth	
Address		Postcode	