**Your answers to this questionnaire will be CONFIDENTIAL (to occupational health) and will not be given to anyone else without your written permission (Consent at bottom of form).**

Once completed please return by email to [david@dbocchealth.com](mailto:david@dbocchealth.com)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Company** | Click here to enter text. | | | | | | | | | | | |
| **Title:** | Click here to enter text. | | | | | | | |  | | | |
| **Forename:** | Click here to enter text. | | | | | | | | **Surname:** Click here to enter text. | | | |
| **Date of Birth:** | Click here to enter text. | | | | | | | | | | | |
| **Address:** | Click here to enter text. | | | | | | | | | | | |
| **Town:** | Click here to enter text. | | | | | | | | **County:** Click here to enter text. | | | |
| **Postcode:** | Click here to enter text. | | | | | | | | **Telephone: -** Click here to enter text. | | | |
| **Mobile:** | Click here to enter text. | | | | | | | | **Email** Click here to enter text. | | | |
| **Role Title:** | Click here to enter text. | | | | | | | | **Department:** Click here to enter text. | | | |
| **HR contact:** | Click here to enter text. | | | | | | | |  | | | |
| **Proposed start date** | Click here to enter text. | | | | | | | |  | | | |
| **The information given by you on any part of this form will be used as the basis of a medical opinion given by our Company Medical Advisors. Please answer all the questions truthfully and completely** | | | | | | | | | | | |
| **Role Profile -** Please identify which occupational groupings most closely fits your potential role: | | | | | | | | | | | |
| Call Centre  Driver (Company Car/Van)  Driver (HGV/LGV)  Factory/Warehouse/Logistics | | Maintenance/Cleaning/Caretakers  Lone Working  Foreign Travel  Management | | | | | | | | Office/Desk based/Sedentary/  Display Screen Equipment User  Other enter text | |
| **Section 1 - General - In order for the company to take reasonable steps to assist you in carrying out your employment please answer the following questions in so far as they are relevant to you:** | | | | | | | | | | | |
| **Question** | | | | | **Response** | | | **If you respond “yes” please provide additional information** | | | |
| Do you suffer from any medical condition, that you feel you would need support with in order to carry out functions which are essential to your proposed employment? | | | | | **Yes  No** | | | Click here to enter text. | | | |
| Are you currently receiving any treatment or investigations for any condition that you feel you may need support with in order to carry out functions which are essential to your proposed employment? | | | | | **Yes  No** | | | Click here to enter text. | | | |
| Do you require any adjustments to be made to your work or work environment due to a medical condition? This includes provision of clinical waste bins etc. | | | | | **Yes  No** | | | Click here to enter text. | | | |
| Is there anything in your history or circumstances which might affect your ability to carry out functions that are essential to the work for which you will be potentially employed? | | | | | **Yes  No** | | | Click here to enter text. | | | |
| **Section 2 - Respiratory** | | | | | | | | | | | |
| **Question** | | | **Response** | | | **If you respond “yes” please provide additional information** | | | | | |
| Do you suffer from any respiratory condition that may be exacerbated by your potential environment, contact with substances or chemicals? | | | **Yes  No** | | | Click here to enter text. | | | | | |
| Do you require any medical support with regard to a respiratory condition? | | | **Yes  No** | | | Click here to enter text. | | | | | |
| From your knowledge of the job that you will potentially be doing, is there anything that you feel may impact on your medical condition? | | | **Yes  No** | | | Click here to enter text. | | | | | |
| Do you have any allergies? | | | **Yes  No** | | | Click here to enter text. | | | | | |
| Are there any adjustments that you feel would be required to allow you to undertake your potential role without impacting on your medical condition? | | | **Yes  No** | | | Click here to enter text. | | | | | |
| **Section 3 – Vision** | | | | | | | | | | | |
| **Question** | | | **Response** | | | **If you respond “yes” please provide additional information** | | | | | |
| Do you wear glasses? | | | **Yes  No** | | | **For Distance  For Reading**  **For Display Screen  All the time** | | | | | |
| Do you have any visual deficits that are not corrected with glasses/contact lenses? | | | **Yes  No** | | | Click here to enter text. | | | | | |
| Have you been diagnosed as having a colour deficit (colour blind)? | | | **Yes  No** | | | Click here to enter text. | | | | | |
| Do you have any visual deficits that you feel would impact on any intrinsic functions of your role? | | | **Yes  No** | | | Click here to enter text. | | | | | |
| **Section 4 - Hearing** | | | | | | | | | | | |
| **Question** | | | | **Response** | | **If you respond “yes” please provide additional information** | | | | | |
| Do you have a hearing deficit? | | | | **Yes  No** | | Click here to enter text. | | | | | |
| Do you have or have you had a medical condition that has caused you to have a hearing deficit? | | | | **Yes  No** | | Click here to enter text. | | | | | |
| Has previous noise exposure contributed to your hearing deficit? | | | | **Yes  No** | | Click here to enter text. | | | | | |
| Have you ever been advised to reduce noise exposure? | | | | **Yes  No** | | Click here to enter text. | | | | | |
| **Section 5 - Skin** | | | | | | | | | | | |
| **Question** | | | | **Response** | | **If you respond “yes” please provide additional information** | | | | | |
| Do you suffer from any skin conditions that may be exacerbated by your environment, contact with substances or chemicals? | | | | **Yes  No** | | Click here to enter text. | | | | | |
| Do you require any medical support with regard to a skin condition? | | | | **Yes  No** | | Click here to enter text. | | | | | |
| From your knowledge of the job that you will potentially be doing, is there anything that you feel may impact on your medical condition? | | | | **Yes  No** | | | Click here to enter text. | | | |
| Are there any adjustments that you feel would be required to allow you to undertake your potential role without impacting on your medical condition? | | | | **Yes  No** | | | Click here to enter text. | | | |
| **Section 6 – Neurology** | | | | | | | | | | |
| **Question** | | | | **Response** | | | **If you respond “yes” please provide additional information** | | | |
| Do you suffer from any condition that causes you to have balance problems or would pose a safety risk to any intrinsic function of your potential role? | | | | **Yes  No** | | | Click here to enter text. | | | |
| Do you or have you ever suffered from any condition that causes you to lose consciousness? | | | | **Yes  No** | | | Click here to enter text. | | | |
| Do you suffer from faints, blackouts, epilepsy or any condition that would pose a safety risk to either yourself, colleagues or the general public? | | | | **Yes  No** | | | Click here to enter text. | | | |
| Do you have any restriction on driving imposed by the DVLA? | | | | **Yes  No** | | | Click here to enter text. | | | |
| Do you have or are you currently being investigated for a learning difficulty, i.e. dyslexia, dyspraxia, ADHD? | | | | **Yes  No** | | | Click here to enter text. | | | |
| **Section 7 – Psychological Health** | | | | | | | | | | |
| **Question** | | | | **Response** | | | **Additional Information** | | | |
| Do you have or have you ever had any psychological conditions that are likely to impact on your ability to undertake your potential role? | | | | **Yes  No** | | | Click here to enter text. | | | |
| Do you feel that you require any adjustments in relation to a psychological condition to enable you to undertake your potential role? | | | | **Yes  No** | | | Click here to enter text. | | | |
| Are there any factors that you feel would impact on your ability to undertake your potential role? | | | | **Yes  No** | | | Click here to enter text. | | | |
| **Section 8 - Musculoskeletal** | | | | | | | | | | |
| **Question** | | | | **Response** | | | **If you respond “yes” please provide additional information** | | | |
| Do you have any medical conditions that affect your muscles, ligaments or joints that may impact on your ability to undertake any aspect of your potential role? | | | | **Yes  No** | | | **Underactive Thyroid- Often has muscle and joint aches.** | | | |
| Do you feel that you require any adjustments in relation to a musculoskeletal concern to allow you to undertake your potential role? | | | | **Yes  No** | | | Click here to enter text. | | | |
| From your knowledge of the job that you will potentially be doing, is there anything that you feel may impact on your medical condition? | | | | **Yes  No** | | | Click here to enter text. | | | |

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| **Declaration – To be** **completed by All Applicants - please tick to indicate acceptance of the above** |
| I hereby declare, to the best of my knowledge and belief, that the above answers are true.  I understand that false statements may render me liable to the Company’s disciplinary procedure which could include dismissal.  I understand that advice will be given to management by the Company’s Occupational Health Practitioners and that only appropriate medical information supplied by me or with my consent, either verbally or written, which will enable my employers to support me in my role or to enable them to make reasonable decisions and adjustments will be divulged by the clinician to my employer.  Signed: …………………………………Date: ………………………………………………….  **It may be necessary for you to be contacted for more information or be requested to attend an appointment with an Occupational Health Practitioner.** |

**David Barber (OH) Ltd is committed to the principles and requirements of both the Access to Medical Reports Act 1988, the Data Protection Act 1998 and General Data Protection Regulations 2018**

In order to comply with HSE guidance and best practice, health screening should be performed at the following intervals;

Safety critical work, including work at heights/confined spaces or lone workers (MHSAW regulations)

Annually

Fork lift or plant driving (HSE legislation – driving and operating mobile plant)

Full health screen - On appointment, after 12 months then 2 yearly

Working with chemicals (COSHH Regulations)

Skin examination and maybe lung function. Blood tests may be performed if necessary - Annually

Hearing (Noise at Work Regulations)

Hearing test on appointment, then after 6 months, then after 1 year, then 2 yearly

Lung function testing (COSHH regulations)

On appointment, then after 6 months, then annually (if exposed to Isocyanates, solvents, flour, grains, epoxy resin, solder fumes, silica, reactive dyes, gluteraldehyde, laboratory animals, powders, oils, wood dust or degreasers)

Night shift workers (European Working Time Directive)

Annually

Display Screen Equipment (regular computer users)

Annually