HEALTH SERVICE EXECUTIVE
PRE-PLACEMENT HEALTH ASSESSMENT FORM
CONFIDENTIAL TO OCCUPATIONAL HEALTH DEPARTMENT

Job Title:	Location:

Sections 1a-8 to be completed by prospective employee and returned to:

OCCUPATIONAL HEALTH UNIT AS INDICATED ON YOUR EMAIL FROM THE NRS

Section 1a: Information for prospective employees regarding confidentiality

1.1 ***All information on this form will be treated as strictly confidential at all times, in accordance with the provisions of the Data Protection Acts (1988 & 2003). No personal or medical information will be disclosed to a third party on an individual identifiable basis without your consent. The purpose of the pre-placement health assessment is:***

- *To determine the prospective employee's fitness to carry out the duties of the post and to assist the HSE in meeting its obligations under the Safety, Health & Welfare at Work Act 2005*
- *To ensure the HSE complies with the Employment Equality Acts (1998 & 2004) by advising on measures that may be required to enable the prospective employee to carry out the duties of the post and render regular and efficient service*
- *To form the basis of a confidential occupational health record. This occupational health record will be held separately from other employment records maintained by the HSE.*

A recommendation regarding your medical fitness for duty will be issued to Human Resources.

Section 2a: Personal details

Family Name:	Family name at birth (if different):
First names:	Date of birth:
Gender:	
Address:	GP Name and address:
Telephone number:	GP telephone number:
Email:	GP email:

Section 3: Present and previous employment, including HSE employment

Please provide details of your previous three posts, starting with your present or most recent post

Job title	Employer name and address	From	To

Section 4: Sickness absence

Have you lost time from work or education due to sickness absence in the past two years?

☐ *Yes* *If yes, please provide the following information:* ☐ *No* *Proceed to section 5*

Dates of absence	No of days absent	No of occasions	Reason for absence

Name:____DOB:______________________

Section 5: Immunity and immunisation status

Clerical or administrative staff who do not have patient contact or contact with laboratory samples are not required to complete this section

Healthcare workers with patient contact are required to provide information relating to their immunity to:

- *TB*
- *mumps*
- *measles*
- *rubella*
- *varicella*
- *hepatitis B (anti-HBs).*

You must forward a completed immunisation/vaccination certificate from your current Occupational Health Department and copies of previous laboratory test results if available*. Failure to provide this information may lead to a delay in health assessment that could affect your start date. If you do not have a current Occupational Health Department you must attend your new Occupational Health Department before commencing your new post. If you have never worked in the HSE your new Occupational Health Department will undertake this screening at your pre-placement health assessment.*

Have you enclosed your immunisation/vaccination records?

☐ Yes

☐ No. State reasons why: ____

1.1.1.1 Healthcare workers with patent contact who may be involved in Exposure Prone Procedures (EPP) are required to submit evidence of non-infectivity to hepatitus B and C. Please provide a copy of your EPP certificate including the following information

- **Hepatitis B core antibody (Anti-HBc)**
- **Hepatitis B surface antigen (HBsAG)**
- **Hepatitus C Antibody**

These tests must be carried out on identity validated samples (IVS). Only results from an Irish or UK occupational health service that has confirmed the identity of the person by checking appropriate photographic ID e.g. passport, driving licence or a photographic ID card will be accepted. For International recruitment, please refer to International recruitment documentation. Your consultant or manager will be advised that you cannot undertake EPP until all the requisite information has been received. If you are aware that you have any infectious disease or other health related condition that may impact upon your work, you have a responsibility to discuss this with the Occupational Health Professional.

Name:____DOB:______________________

Section 6: Health and ability declaration

Have you suffered from tuberculosis (TB)* ☐ Yes ☐ No

Within the past 12 months:

- Has a family member or close contact has been treated for TB ☐ Yes ☐ No
- Have you had a cough for more than three weeks ☐ Yes ☐ No
- Have you coughed up blood ☐ Yes ☐ No
- Have you suffered unexplained weight loss ☐ Yes ☐ No
- Have you suffered from night sweats or fever ☐ Yes ☐ No
- Have you visited a foreign country for more than one month within the last five years* ☐ Yes ☐ No

(name of country and duration of visit ____)

* those who have spent time in countries with a high incidence of TB (40/100, notified per year). HPSC Guidelines on the Prevention and Control of Tuberculosis in Ireland (2010).

Please tick one of the following options:

☐ I am not aware of any health condition or disability that might affect my ability to undertake effectively the duties of the position that I have been offered.

☐ I do have a health condition or disability that might affect my ability to undertake effectively the duties of the position that I have been offered, and that might require special adjustments to my work or my place of work. ***(Please answer the questions below.)***

- Have you had a medical condition or operation in the past five years ☐ Yes ☐ No
- Are you receiving treatment (including tablets and injections, oral contraceptives or HRT) but excluding *include self-medication, physiotherapy, chiropractic treatment, psychological counselling or other support* ☐ Yes ☐ No
- Have you suffered a work-related illness or injury, or given up work due to ill health ☐ Yes ☐ No
- Do you have an impairment/disability (including intellectual disability) (including visual impairment, hearing impairment, dyslexia, dyspraxia etc) ☐ Yes ☐ No
- Have you received work adjustments during previous employment/education (special equipment, access, mobility, restricted duties, shift adjustment etc) ☐ Yes ☐ No
- Have you suffered back, neck, joint or muscle problems ☐ Yes ☐ No
- Have you suffered from skin problems, allergies and/or immune disorders ☐ Yes ☐ No
- Have you suffered from a mental disorder (including depression, anxiety, self-harm, eating disorder, psychological or emotional problems) ☐ Yes ☐ No
- Have you had a drug or alcohol abuse problem or other addiction ☐ Yes ☐ No

If you ticked any of the boxes above please advise:

- When and for how long you had the problem
- What type of treatment you received
- Whether you were admitted to hospital, unable to work or prevented from carrying out your normal activities because of the problem
- Whether the condition affects you now in any way:

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Name:____DOB:______________________

Section 7: Declaration by applicant

Please read the declaration below carefully

I declare that the information I have given is true and complete to the best of my knowledge and th have not withheld any material facts. I understand that I am responsible for the accuracy of my statement. I understand, accept and confirm the entitlement of the Health Service Executive to reje my application or terminate my employment (in the event of a contract of employment having beer entered into) where I have omitted to furnish any information relevant to this health assessment or where I have made any false statement or misrepresentation relevant to this health assessment

I understand that the medical information given by me is confidential to the Occupational Health service and will not be disclosed to any other person without my explicit consent. A report on my fitness for the position offered will be given to management along with any recommendation for work adjustments that may be appropriate.

understand that I may be required to undergo an assessment by Occupational Health if considered necessary. I agree to a relevant Occupational Health record being kept for the duration of my employment. I accept that I have an ethical and professional obligation to inform the Occupational Health service, in confidence, if I am HIV positive/hepatitis B positive/hepatitis C positive in accordance with Department of Health guidelines.

Signed: ______________________ *Date:* ______________________