Occupational Health- Health Declaration

CONFIDENTIAL MEDICAL INFORMATION

PLEASE COMPLETE ELECTRONICALLY AND E-MAIL TO:
OCCUPATIONALHEALTH@WAIRARAPA.DHB.ORG.NZ

It is a condition of your employment with Wairarapa District Health Board (WrDHB) that a health clearance is obtained **BEFORE COMMENCING WORK. Please allow at least two weeks before your start date for a health clearance to be obtained.**

The purpose of this questionnaire is to ensure that all new employees of WrDHB are fit to perform the job for which they are employed; to ensure staff and patient safety and to assess the need for occupational support.

The information will be collected in accordance with the Privacy Act (1993) and the Health Information Privacy Code (1994). This declaration will be treated as a confidential medical record by WrDHB Occupational Health & Safety Service who will give recommendations to the relevant manager regarding fitness to work only. No medical details will be divulged to managers or any other employees in the organisation without the employee's permission. If a workplace injury occurs in the future insurers may, with the employee's consent, request information to determine eligibility for cover.

- **For patient contact positions (includes clinical workers, ward administrators, orderlies) please complete ALL sections.**
- **For non-patient contact positions please complete sections – A,B,C, F & G.**

SECTION A: PERSONAL DETAILS			
Name:			
Previous Name(s)			
Date of Birth:		**Ethnicity:**	
Address:			
NHI (if known):		**Gender:**	
GP or Practice Name:			
Home Phone:		**Mobile Phone:**	
Email Address:			
Position Offered:			
Start Date:		**Manager:**	
Ward/Department:			
Have you previously been employed by WrDHB?	**Please Select.** Year employed:	Year resigned:	

SECTION B: General Questions	
1. Do you have any health issues that may affect your ability to perform your duties?	**Please Select.**
2. Do you require any workplace modifications?	**Please Select.**
3. **WrDHB has a Smoke-free Policy** which prohibits workers and visitors from smoking anywhere in its facilities or grounds. If you smoke and would like assistance to quit, smoking cessation support is available through the Smoke-free Coordinator or QUITLINE 0800 778 778 .	I would like the Smoke-free Coordinator to contact me to discuss the smoking cessation programme: **Please Select.**

4. **Vision** - Do you wear corrective lenses?	**Please Select.**
Do you have any vision difficulties aside from wearing glasses/corrective lenses?	**Please Select.**
5. **Hearing** - Do you have any hearing difficulties?	**Please Select.**
Have you previously worked in a noisy environment?	**Please Select.**
Have you ever had a hearing test?	**Please Select.**
6. **Allergies or Sensitivities** - Do you have any allergies or sensitivities?	**Please Select.**
What is your allergy/ sensitivity to?	- Latex **Please Select.** - Other **Please Select.**

SECTION C: Musculoskeletal	
The position you have applied for may require you to perform tasks including the following: moving patients or objects, prolonged standing or sitting, pushing, pulling, reaching, bending, computer use, restraint of patients/clients or repetitive tasks.	
1. Have you ever had a sprain or strain which has affected your ability to work for more than five days?	**Please Select.**
2. Have you ever had any discomfort, pain or injury (back, neck, shoulder or arm) which built up over time due to repetitive physical activity?	**Please Select.**
3. Do you have any other musculoskeletal conditions (back, shoulders, legs, feet) that may affect your ability to work?	**Please Select.**
If you answered yes to any of the questions above please give details including date, cause and diagnosis, ACC claims, time off work, and any residual problems/treatment/medication required:	

SECTION D: Infection Control	
WrDHB screens staff for infectious diseases including chicken pox, measles, rubella and hepatitis B. If you do not have immunity, vaccination is recommended – please discuss with Occupational Health. **WrDHB must know the hepatitis B immunity status of clinical staff. This is important for any potential blood/body fluid exposure in the future.**	
1. Skin Assessment - Have you ever had a skin condition?	**Please Select.**
Have you ever suffered from:	- Eczema/Dermatitis: **Please Select.** - Psoriasis: **Please Select.**
Do affected areas include hands, arms, face, neck or head?	**Please Select.**
Is it currently active?	**Please Select.**
Are you currently having treatment for this?	**Please Select.**
If you have a history of having had a desquamating skin condition, a nasal swab for MRSA is required	
2. Chicken Pox - Have you ever had chicken pox?	**Please Select.**
Have you ever been vaccinated against chicken pox or been tested for immunity?	**Please Select.**
3. Measles - Do you have a documented record of having had two MMR vaccinations?	**Please Select.**
If you do not have a vaccination record, have you had a blood test for immunity?	**Please Select.**
4. Rubella- Do you have a documented record of having had two MMR vaccinations?	**Please Select.**
If you do not have a vaccination record, have you had a blood test for immunity?	**Please Select.**
5. Hepatitis B - Have you been vaccinated against Hepatitis B?	**Please Select.**
Have you been screened for Hepatitis B? please supply antibody level	**Please Select.**
6. Influenza - When were you last vaccinated?	Date:
7. Pertussis (whooping cough) – Will you be working with babies/children?	**Please Select.**
When were you last vaccinated against pertussis?	Date:

SECTION E: TUBERCULOSIS	
1. Country of birth and/or where were you predominately raised?	
2. How long have you lived in New Zealand?	**Years** **Months**
3. If you have worked in a healthcare setting outside of New Zealand in the last two years, please state countries and length of time worked in each	
4. Have you ever had a Mantoux (tuberculin skin test) test for TB?	**Please Select.**
5. Have you ever had a Quantiferon TB Gold blood test for TB?	**Please Select.**
6. Have you had a recent chest x-ray related to TB screening or exposure?	**Please Select.**
7. Have you had contact with TB without respiratory protection?	**Please Select.**
8. Have you been part of a contact tracing exercise for TB?	**Please Select.**
If you answered 'Yes', did you comply with all recommendations e.g. take prescribed medication or complete investigations?	**Please Select.**
9. Have you ever been diagnosed with TB or been given medication for TB?	**Please Select.**
10. Do you have any medical condition or are you taking any medication which causes depression of your immune system e.g. renal failure, organ transplant, cancer, HIV or taking prednisone?	**Please Select.**
11. Have you, in the last 2 years, experienced any of the following symptoms (lasting a month or more)?	
- Unexplained weight loss?	**Please Select.**
- Unexplained night sweats?	**Please Select.**
- Undiagnosed cough?	**Please Select.**
- Undiagnosed shortness of breath?	**Please Select.**
- Swellings under the arm or around the head/neck region?	**Please Select.**
- Coughing up blood?	**Please Select.**

SECTION F: OTHER	
Is there anything else you wish to let us know about?	**Please Select.**

SECTION G: PRIVACY AND DECLARATION STATEMENT
Clinical employees are reminded to consider their own risk of infection from blood-borne pathogens (hepatitis B, hepatitis C and HIV) and the associated risk of transmitting infection to patients. Professional bodies (NZ Medical Association, NZNO, Australasian College of Surgeons etc.) have statements relating to this, and workers should acquaint themselves with the appropriate association policies. Any employee who is a carrier of a blood-borne disease and knowingly expose their patients to a risk of infection based on their own risk assessment, without seeking further counselling, could be open to disciplinary proceedings.
I declare to the best of my knowledge that the information I have given in this questionnaire is correct. I understand that giving false or misleading information or suppressing information may be a reason for disciplinary action to be taken against me if I am employed by WrDHB. I understand that I may request access to and update my personal information if I need too. I consent to this information being used by WrDHB Occupational Health and Safety Service to make decisions regarding my employment and for on-going monitoring of the hazards to which I may be exposed while employed by WrDHB. I consent to information regarding infection prevention and control, e.g. proof of immunity to specific infectious diseases and vaccination history, being passed on to any other New Zealand District Health Board for the purposes of pre-employment screening.
☐ **I have read and understood the above declaration statement**

Once completed please e-mail this form, along with any required test results to:
occupationalhealth@wairarapa.dhb.org.nz

Office use only: Cleared Yes ❒ No ❒

Signed: …… Date: ……..

Comments:

Manager's clearance email sent Yes ❒ No ❒

To whom: ……. Date: ……