HEALTH-CARE WORKER OCCUPATIONAL HEALTH QUESTIONNAIRE AND DECLARATION

Name			
Home Number		**Cell Phone Number**	
NMH position applied for			
NMH Department			
NMH	❑ Nelson ❑ Wairau ❑ Other _____		
Anticipated Start Date			
Appointing Manager			
Previously employed by NMDHB?	❑ Yes ❑ No		

Please read before completing the attached questionnaire.

These questions relate to requirements for the job you are applying for – we wish to ensure your employment with Nelson Marlborough Health (NMH) would not place you, the patients or your colleagues at risk. The questions are also designed to identify any personal health issues that you have that could be potentially affected by work at NMH or that would benefit from additional assistance.

Your information will be managed in accordance with the Health and Safety at Work Act (HSWA), 2015, Privacy Act 1993 and the Health Information Privacy Code 1994. Your information will be treated confidentially by Occupational Health who will give recommendations to your Manager and the Human Resource Department regarding your fitness to work. No health details will be divulged without your permission. Should you have an injury in the future, however, WorkAon our claim administrators may request your consent to access the information pertaining to your injury to determine eligibility for cover.

If you wish to confidentially discuss any aspect of your health or if you are unclear as to the intent of the questions please do not hesitate to contact:

Nurse Co-ordinator
Occupational Health, Safety and Wellbeing
NMH
Phone 03-546-1800 ext 7718
Cell Phone 027 241 8903

Appointments to NMH may not be confirmed unless there is satisfactory completion of this questionnaire and the information provided does not indicate an Occupational Health risk. You may be contacted for further information if the information on your questionnaire is not clear or complete, or raises any concerns.

What has been your previous work experience

❑ Clerical/Admin	❑ Nursing/Midwives	❑ Medicine
❑ Support Worker	❑ Allied	❑ Other _____

What has been your previous hazard exposure

Previous Work	Hazards Exposed To	How were you affected by the Hazard

General Questions

1. Have you ever had a manual handling injury, sprain or strain, which has affected your ability to work? *If yes, please detail:* _____ _____	❑ Yes ❑ No
2. Has your ability to function or work ever been affected by an overuse problem or repetitive strain injury eg., DPI, OOS, RSI etc.,? *If yes, please detail:* _____ _____	❑ Yes ❑ No
3. Has your ability to function or work ever been affected by back, neck, shoulder or arm problems? *If yes, please detail:* _____ _____	❑ Yes ❑ No
4. Do you have any physical or mental health condition or injury that may impact on your ability to work now or in the future? *If yes, please detail:* _____ _____	❑ Yes ❑ No
5. In the clinical areas you may be required to perform some procedures on the floor such as resuscitation and physical restraint. Will you be able to manage this? *If no please detail:* _____ _____	❑ Yes ❑ No
6. Do you have any health condition or injury that may impact on your ability to maintain an Annual Practicing Certificate, or obtain an Annual Practicing Certificate in the future? *If yes, please detail:* _____ _____	❑ Yes ❑ No
7. Do you take any medication/s which may impact on your ability to do your job? *If yes, please detail:* _____	❑ Yes ❑ No

_____	
8. Do you have any problem with your hearing which may impact on your ability to do your job? *If yes, please detail:* _____ _____	❑ Yes ❑ No
9. Do you have any visual impairment which may impact on your ability to do your job? *If yes, please detail:* _____ _____	❑ Yes ❑ No
10. Do you have any needs relating to a condition, injury or disability which may require support to do your job including work station requirements? *If yes, please detail:* _____ _____	❑ Yes ❑ No

Declaration
I declare to the best of my knowledge, the information I have given in this questionnaire is true and correct. I understand giving false or misleading information, or suppressing information may jeopardise my employment or be a reason for future disciplinary action.

Name: _____ **Signed:** _____

Date: _____ / _____ / _____

OCCUPATIONAL HEALTH ONLY TO COMPLETE

- ❑ Sighted – suitable to appoint – no action required
- ❑ Sighted – suitable to appoint – some action taken – appointing Manager advised
- ❑ Sighted – action taken – recommendations made to appointing Manager

Action _____

_____

_____

Name: _____**Signed:** _____

Date: _____ / _____ / _____