CONFIDENTIAL

Staff Health and Wellbeing Department
Standing Way, Eaglestone
Milton Keynes MK6 5LD
Telephone 01908 995255
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APPLICANT'S HEALTH STATEMENT

The purpose of this health statement is to establish if you have any health conditions that could affect your ability to undertake the duties of the post you have been offered and to ensure that your health is not placed at risk within the workplace. The information supplied in this form is confidential to the Department and will not be disclosed to any other person(s) without your written consent. Milton Keynes University Hospital NHS Foundation Trust, as an equal opportunities employer, seeks to promote equality in the workplace. It does not discriminate against those who have a disability but seeks to limit the impact of the disability by fulfilling its duties as specified in the Equality Act 2010. The Department may contact you or offer you an appointment to be seen if this is considered necessary, and may recommend adjustments where appropriate. Once completed, this form should be returned via email to voluntary.services@mkuh.nhs.uk.

A. PERSONAL DETAILS Please complete all sections fully in black ink/print and in capitals

Post:	Department VOLUNTEERING	Manager's name **SARAH WOODFIELD**
	Clinical service unit **CORPORATE**	Manager 's contact number **01908 996058**

Surname	Forename	Title
Maiden/previous name if applicable:		Date of Birth:
Current address: Post Code:		
Personal e-mail:	Country of birth- **if born outside of the UK please complete Section E question 3**:	
Mobile Telephone:	Home telephone:	

B. DETAILS OF PREVIOUS EMPLOYMENT Please continue on a separate sheet if necessary

Employer's Name	Job title	Start and finish dates
1.		
2.		
3.		

C. SICKNESS ABSENCE

Please indicate time lost from work or education in the last 3 years due to illness.
Put nil / zero if none. Continue on a separate sheet if necessary. Do not leave this section blank.

Dates	Length of absence	Reason for absence

D. HEALTH CONDITIONS **Please answer the questions as fully as possible.**	**Yes**	**No**	**If YES, please provide further details:** Name of condition, date diagnosed, current treatments, ongoing problems and how you feel this would affect your ability to do your work. Continue on a separate sheet if necessary.
1. Do you have any health condition/impairment/disability (physical or mental) which may affect your ability to do your work? **If yes**, please provide details	☐	☐	
2. Have you ever had any illness/impairment/disability which may have been caused or made worse by your work? **If yes**, please provide details	☐	☐	
3. Are you having, waiting for treatment, undergoing investigations or taking medication at present? **If yes**, please provide details	☐	☐	
4. Do you think you may need any adjustments or assistance to help you to do the job? **If yes**, please provide details	☐	☐	
E. TB (TUBERCULOSIS) SCREENING	**Yes**	**No**	**If ' YES ' to any of the questions below please give details:**
1. Have you ever had TB?	☐	☐	
2. Have you, or any close friend or relative, had TB or been in recent contact with open TB?	☐	☐	
3. Have you lived or worked in a country other than the UK? **If yes,** please list all the countries that you have lived or worked in, the dates and the length of your stay.	☐	☐	
4. Do you have any condition that could impair your immune system e.g. HIV, long term steroid treatment, chemotherapy?	☐	☐	
Do you have any of the following symptoms?	**Yes**	**No**	**Please give details:**
A persistent cough	☐	☐	
Unexplained weight loss	☐	☐	
Unexplained fever +/- night sweats	☐	☐	
Have you ever had a Heaf /Mantoux test or Quantiferon/TB Elispot blood test? **If yes,** please provide documentary of the result	☐	☐	
Have you had a BCG vaccination? **If yes**, please provide documentary evidence	☐	☐	
Have you had a chest X-ray in the last 12 months? **If yes**, please provide documentary evidence of the result	☐	☐	

F. SKIN CONDITIONS	Yes	No	If ' YES ', please give details:
1. Do you have any skin conditions? E.g. eczema, psoriasis, allergic or contact dermatitis especially if it affects your hands? **If yes,** please give details including dates, symptoms and treatment	☐	☐	
2. Do you have an allergy to Latex? **If yes,** please give details	☐	☐	

G. FOR EPP* WORKERS:

- Please supply copies of any previous blood test confirming your Hepatitis B and Hepatitis C status.
- Please note that for these to be accepted, they must be from an **Identified Validated Sample (IVS).** An Identified Validated Sample is one taken in a UK NHS Occupational Health Department from the health care worker whose identity is confirmed at the time by photographic evidence (passport, driving licence etc). If results are not available you will be tested in this Department. **Health clearance for EPP work is needed before fitness for the job can confirmed.**
- ***EPP** (**Exposure Prone Procedures)** are those procedures where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissue (e.g. spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times. Examples of EPP staff include all surgeons, midwives, A&E staff, theatre staff and some dental staff. If you are not sure if you are an EPP staff, please contact the Department.

H. IMMUNISATIONS: (for all staff who come into contact with patients or go into patient areas)

Please include copies, with this form, of official documentation of all blood results and immunisations that may have been taken for occupational health reasons. The records can usually be obtained from your General Practitioner (GP) and/or your Occupational Health Department. **This may reduce the need for you to have further injections and blood-tests.**

Please provide evidence of the following (either immunisations and/or blood tests):

Chicken Pox (Varicella)	Diphtheria/Tetanus/Polio
Hepatitis B	TB skin test (Heaf/Mantoux) and result
MMR (Measles Mumps and Rubella)	TB Ellispot / Quantiferon

I. DECLARATION BY APPLICANT

I confirm that the information given on this form is true and complete. I understand that if any information is false or has been deliberately omitted, I may be regarded as ineligible for employment or liable to be dismissed. I understand that medical details will not be divulged without my permission to any person outside the Service, but an opinion about my fitness to work and advice on adjustments, if required, will be given to management. I agree to a Health record being kept recording my health while at work.

Signature:	**Date:**

J. TO BE COMPLETED BEFORE SUBMISSION

	Please cross
I have completed all the relevant sections of the form fully	☐
I have attached copies of relevant blood tests and immunisations as requested in this form	☐
I have completed the declaration above, signed and/or printed my name and dated the form	☐