5. Self-Declaration Forms

Schedule One: Pre-placement Health Declaration Form

Section 1: Personal details

Surname: _____ First names: _____

Surname at birth: _____ PPS Number: _____

Email: _____

Address: _____

Date of Birth: _____ Gender: _____

Home Telephone: _____ Mobile Telephone: _____

GP Name: _____ GP Telephone: _____

GP Address: _____

Section 2: Present and previous employment

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

Job Title	Employer Address	From	To

Section 3: Sickness absence

Please indicate time lost from work or education in the last 2 years due to illness

Date and length of absence	Reason for absence

Section 4: Questionnaire

Please tick the appropriate **Yes** or **No** box for the following questions.

Please give details

1. Do you have, or have you ever had, any medical conditions or operations in the past 5 years?

YES ☐ NO ☐

If yes, please give details _____

2. Are you at present attending a doctor for medical care, taking any medication or on a waiting list for hospital assessment or treatment?

YES ☐ NO ☐

If yes, please give details _____

3. Have you ever suffered a work-related illness, or given up work because of ill health?

YES ☐ NO ☐

If yes, please give details _____

4. Do you have any impairment/ disability (physical or mental) or specific learning disability which may affect your ability to work?

YES ☐ NO ☐

If yes, please give details _____

5. Have you ever suffered from tuberculosis (TB)? YES ☐ NO ☐

a. Within the past 12 months YES ☐ NO ☐

b. Has any family member or close contact been treated for TB? YES ☐ NO ☐

c. Have you had a cough for more than 3 weeks? YES ☐ NO ☐

d. Have you coughed up blood? YES ☐ NO ☐

e. Have you had any unexplained weight loss? YES ☐ NO ☐

f. Have you suffered from night sweats or fever? YES ☐ NO ☐

If you answered yes to any of the above , please give details _____

_____

6. Have you ever had any kind of back, joint or muscle problem?

YES ☐ NO ☐

If yes, please give details _____

7. Have you ever had: Dermatitis, Eczema, Psoriasis or any other skin condition?

YES ☐ NO ☐

If yes, please give details _____

8. Have you ever had any mental illness which might affect your ability to work? (including anxiety, depression, self-harm, eating disorders, psychological or emotional problems)

YES ☐ NO ☐

If yes, please give details _____

9. Have you ever had a drug or alcohol problem?

YES ☐ NO ☐

If yes, please give details _____

10. Do you have difficulty with your eyesight (including colour blindness)?

YES ☐ NO ☐

If yes, please give details _____

11. Do you have difficulty with your ears or hearing?

YES ☐ NO ☐

If yes, please give details _____

12. Have you ever suffered from any of the following: loss of consciousness including fainting attacks, blackouts, dizziness, epilepsy?

YES ☐ NO ☐

If yes, please give details _____

13. Have you ever suffered from any of the following; heart disease or circulatory problems: including high blood pressure, varicose veins?

YES ☐ NO ☐

If yes, please give details _____

14. Have you ever suffered with chest or lung problems; Asthma, Bronchitis?

YES ☐ NO ☐

If yes, please give details _____

15. Do you have any allergies; including allergies to drugs, food or latex?

YES ☐ NO ☐

If yes, please give details _____

16. Have you ever received treatment for a bowel or gastric problem?

YES ☐ NO ☐

If yes, please give details _____

17. Have you ever suffered a disorder of the bladder or kidneys?

YES ☐ NO ☐

If yes, please give details _____

18. Do you have any other medical condition not previously mentioned in questions 1- 17 above?

YES ☐ NO ☐

If yes, please give details _____

Section 5: Immunity and Immunisation Status

Healthcare Workers with Patient Contact: General requirements
All healthcare workers with patient contact are required to provide information relating to their immunity to TB, Mumps, Measles, Rubella, Varicella and Hepatitis B (anti-HBs). Please include copies of previous laboratory test results.

Immunisations and Immunity Status (Please complete)

Exposure Prone Procedures (EPP)
In addition to the above, employees who may be involved in exposure prone procedures are required to submit evidence of non-infectivity to hepatitis 8 and C. The following are required:

- Hepatitis 8 core antibody (Anti-H8c)
- Hepatitis 8 surface antigen (HBsAG)
- Hepatitis C antibody

Tests must be carried out on identified 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 license 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 Exposure Prone Procedures 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 these with the Occupational Health Professional.

Specific requirements of Health Care Workers performing Exposure Prone Procedures

Hepatitis B antibody (Anti-HBs)	Date checked:	Result:
Hepatitis B core antibody (Anti-HBc)	Date checked:	Result:
Hepatitis B surface antigen (HBsAG)	Date checked:	Result:
Hepatitis Be antigen (HBeAG) (If Hepatitis B surface antigen test is positive)	Date checked:	Result:
Hepatitis B viral load (If Hepatitis B surface antigen I Hepatitis Be antigen test is positive)	Date checked:	Result:
Hepatitis C antibody	Date checked:	Result:
Hepatitis C virus RNA (If Hepatitis C antibody test is positive)	Date checked:	Result:

The above tests for Hepatitis B & C must be taken and processed in line with Identified Validated Specimen (IVS) standards and must be completed, signed and stamped by an Occupational Health Professional.

To facilitate an efficient process, I agree that the Occupational Health Professional can obtain my immunisation and screening results from the Occupational Health Professional in my previous employment

YES ☐ NO ☐

Official Stamp

Please provide the name and address of your last Occupational Health Provider.

Name of occupational health provider: _____

Address: _____

Section 6: Declaration by Applicant

I declare that I understand, accept and confirm the entitlement of the (agency) to reject my application or terminate my employment (in the event of a contract of employment having been entered into) where I have omitted to furnish the Agency with any information relevant to this health assessment or where I have made any false statement or misrepresentation relevant to this health assessment

Signed: _____ Date: _____

Print Name: _____