

Please attach additional sheets of paper if necessary.		
All staff groups complete this section		
	Yes	No
Do you have any illness/impairment/disability (physical or psychological) which may affect your work?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?	<input type="checkbox"/>	<input type="checkbox"/>
Are you having, or waiting for treatment (including medication) or investigations at present? If your answer is yes, please provide further details of the condition, treatment and dates	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you may need any adjustments or assistance to help you to do the job?	<input type="checkbox"/>	<input type="checkbox"/>

Tuberculosis		
Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2006)		
	Yes	No
Have you lived continuously in the UK for the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
If you answered no above, please list all of the countries that you have lived in over the last 5 years		
Have you had a BCG vaccination in relation to Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
If you answered yes please state when	Date	

Tuberculosis Continued		
	Yes	No
Do you have any of the following		
A cough which has lasted for more than 3 weeks	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained fever	<input type="checkbox"/>	<input type="checkbox"/>
Have you had tuberculosis (TB) or been in recent contact with open TB	<input type="checkbox"/>	<input type="checkbox"/>

Chicken Pox or Shingles		
Have you ever had chicken pox or shingles		
Yes	No	Date

Immunisation History					
Have you have any of the following immunisations			Yes	No	Date
Triple vaccination as a child (Diphtheria / Tetanus / Whooping cough)					
Polio					
Tetanus					
BCG Vaccination					
TWO M.M.R's					
Varicella (Chickenpox)					
Hepatitis B (If Yes is ticked please give dates below)					
Course:	1	2	3		
Boosters:	1	2	3		

HIV					
Have you had a HIV Test	Yes	No	Date	Result:	
Do you have reason to believe that you may have been exposed to HIV infection				Yes	No

HEPATITIS C					
Have you had a Hep C antibody Test	Yes	No	Date	Result:	
Do you have reason to believe that you may have been exposed to Hep C infection				Yes	No

Proof of Immunity (Please send the following)	
Varicella	You must provide a written statement to confirm that you have had chicken pox or shingles however we strongly advise that you provide serology test result showing varicella immunity
Tuberculosis	We require an occupational health/GP certificate of a positive scar or a record of a positive skin test result (Do not Self Declare)
Rubella, Measles & Mumps	Certificate of “two” MMR vaccinations or proof of a positive antibody for Rubella Measles & Mumps
Hepatitis B	You must provide a copy of the most recent pathology report showing titre levels of 100lu/l or above

Proof of Immunity (Please send the following) EPP Candidates Only	
Hepatitis B Surface Antigen	Evidence of a negative Surface Antigen Test Report must be an identified validated sample. (IVS)
Hepatitis C	Evidence of a negative antibody test Report must be an identified validated sample. (IVS)
HIV	Evidence of a negative antibody test Report must be an identified validated sample. (IVS)

Important Information (IVS)
An IVS report defined according to the following criteria
The healthcare worker should show proof of identity with a photograph – NHS trust identity badge, new driver’s licence, credit cards, passport or national identity card – when a sample is taken.

Exposure Prone Procedures		
Will your role involve Exposure Prone Procedures	Yes	No

Recommendations	
I understand that if any recommendations to my employer are necessary as a result of this Assessment.	
I give consent for the Healthier Business UK Ltd to make recommendations to my employer, without me having seen a written copy of the recommendations first	<input type="checkbox"/>
I would like to see a written copy of any recommendations the Health and Work Centre may make to my employer before they are sent to my employer.	<input type="checkbox"/>

Declaration		
I declare that the answers to the above questions are true and complete to the best of my knowledge and belief		
Name	Signature	Date