PLEASE RETURN TO - occupational.health@derbyshire.gov.uk

(ALL SECTIONS OF THIS FORM MUST BE COMPLETED OR IT WILL BE RETURNED)

|  |
| --- |
| Ref. |

**Pre-Placement Questionnaire  
  
Section A – Please complete this section before issuing to applicant**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Surname |  | Forenames |  | Title |  |

|  |  |
| --- | --- |
| Address and postcode |  |
| Telephone number |  |
| E-mail address |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Job Title |  | Base/School/Department |  |

|  |
| --- |
| **Results to be sent to: Please complete the full name, address and the email address, you wish the result to be sent to.** |
|  |

## **Section B - This section to be completed by Occupational Health**

|  |  |
| --- | --- |
| Recommendations  Is it likely that the Equality Act 2010 applies?  Sign and date |  |

## **Section C – This section to be completed by applicant**

|  |  |
| --- | --- |
| Have you ever been employed by Derbyshire County Council | Yes/No |

|  |  |  |  |
| --- | --- | --- | --- |
| If yes, Job(s) |  | Dates employed |  |
| What is your height? |  | What is your weight? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| National Insurance number |  | Date of birth |  |

**Immunisation History – Have you ever had these immunisations (give dates if known)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Polio | Yes/No |  | Rubella | Yes/No |  |
| Tetanus | Yes/No |  | TB (BCG) | Yes/No |  |
| MMR | Yes/No |  | Hep B | Yes/No |  |

## **Section D – To be completed by applicant – Give as much detail as possible to enable Occupational Health to give a quick decision**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
| 1. | Mental ill health, anxiety, depression |  |  |
| 2. | Fits, blackouts, giddiness |  |  |
| 3. | Chest or lung trouble/cystic fibrosis/severe asthma/COPD/emphysema/ bronchitis |  |  |
| 4. | High BP/heart disease such as heart failure |  |  |
| 5. | Bone/joint disease |  |  |
| 6. | Back trouble |  |  |
| 7. | Stomach trouble |  |  |
| 8. | Kidney/bladder disease/dialysis |  |  |
| 9. | Skin trouble |  |  |
| 10. | Hay fever/other allergies |  |  |
| 11. | Diabetes |  |  |
| 12. | Colour vision defects |  |  |
| 13. | Vision impairment |  |  |
| 14. | Hearing impairment |  |  |
| 15. | Typhoid/paratyphoid fever |  |  |
| 16. | Dysentery, food poisoning or recurring diarrhoea |  |  |
| 17. | Boils, carbuncles, septic fingers |  |  |
| 18. | Discharging ears |  |  |
| 19. | Recurrent nose/throat infection |  |  |
| 20. | Have you had ever had any treatment or counselling for solvent misuse, drug or alcohol problems? |  |  |
| 21. | Have you been rejected/retired on medical grounds from any previous job? |  |  |
| 22. | Has any proposal for life assurance been declined, withdrawn or accepted on special terms? |  |  |
| 23. | Are you taking medication? |  |  |
| 24. | Have you ever been admitted to hospital? |  |  |
| 25. | Have you had any operations? |  |  |
| 26. | Will you require leave of absence on medical grounds in the future? |  |  |
| 27. | Have you had any sickness absence in the last 2 years? |  |  |
| 28. | Do you consider yourself to be disabled/likely to fall within the Equality Act 2010? |  |  |
| 29. | Are you pregnant? |  |  |
| 30. | Are you requested to have the flu vaccine on medical grounds? |  |  |
| 31. | Do you have cancer? Are you undergoing active chemotherapy/radiotherapy or any other treatment? |  |  |
| 32. | Do you have a cancer of the blood or bone marrow such as leukaemia or lymphoma? |  |  |
| 33. | Are you taking any immunosuppression medications? |  |  |
| 34. | Have you any chronic liver disease e.g. hepatitis? |  |  |
| 35. | Do you have any neurological conditions such as Parkinson’s/multiple sclerosis or motor neurone? |  |  |
| 36. | Are you seriously overweight with a body mass index (BMI) of over 40? |  |  |
| 37. | Have you been diagnosed with Long Covid? |  |  |
| 38. | Have you been diagnosed with Fibromyalgia/Chronic fatigue/ME? |  |  |
| 39. | Have you a diagnosed Neurodiverse condition /awaiting diagnosis/have symptoms? |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signed |  | Date |  |

**Please give details if you have answered yes to any of the above (including dates and duration of problems)**

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| --- |
|  |

Declaration – I declare that I have checked the details I have given and to the best of my knowledge they are correct. I realise that any deliberately false or statements or omissions may prejudice my continued employment. I understand that I may be requested to attend a medical assessment