City of Bradford MDC
www.bradford.gov.uk

Health Declaration

Post Applied For: …… HR Contact: ……

Post Reference: ……...Line Manager……..

TO BE COMPLETED BY THE APPLICANT

Mr/Mrs/Miss/Ms Surname: ……. Forenames: ……

Previous Names: …… Date of Birth: ……

Address: ……

Post Code: …… E-mail: ……

Daytime telephone numbers where you can be contacted: GP: ……

Home: …….. Address: ……

Work: …… Post Code: ……

Mobile: ……..

IMPORTANT:

Your answers to this questionnaire will be **CONFIDENTIAL** to the Employee Health and Wellbeing department and will not be given to anyone else without your written permission. The purpose of the questionnaire is to see whether you have any health problems that could affect your ability to undertake the duties of the post you have been offered or place you at any risk in the workplace. We may recommend adjustments or assistance as a result of this assessment to enable you to do the job. Our aim is to promote and maintain the health of all people at work. Before health clearance is given for employment you may be contacted by the Employee Health and Wellbeing Department and may need to be seen by an occupational health nurse or physician.

SECTION 1- Occupational History – Over the last 5 years

Please list your previous occupations (present occupation first)				
DATES		**EMPLOYERS**	**OCCUPATION**	**Exposure to hazards, e.g. noise, dust, fumes, manual handling, asbestos, lead, vibration tools**
from	to			

Clinical Diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2011)				
Have you lived continuously in the UK for the last 5 years?	Yes	No		
If no, please list all of the countries you have lived in over the last 5 years:				
Have you had a BCG vaccination in relation to Tuberculosis?	Yes	No		
If yes please give the approximate date of your vaccination:	Date:			
Do you have any of the following? a) Unexplained weight loss? b) A cough that has lasted for more than 3 weeks? c) Unexplained fever? d) Have you had tuberculosis (TB) or been in recent contact with open TB? e) Have you been in recent contact with a known case of open TB? If yes, please give details below:			**YES** **YES** **YES** **YES** **YES**	**NO** **NO** **NO** **NO** **NO**

SECTION 2 – All staff groups to complete this section

1. Do you have any illness / impairment /disability (physical or psychological) which may affect your ability to work? If yes, please give details below:	**YES**	**NO**
2. Have you ever had any illness / impairment or disability which may have been caused or made worse by your work? If yes, please give details below	**YES**	**NO**

3. Are you currently having, or awaiting to commence treatment including medication and or investigations at present? If your answer is yes please provide further details of the condition, treatment and dates.	**YES**	**NO**
4. Do you think that you may need any adjustments or assistance to help you carry out this role?	**YES**	**NO**

For Occupational Health use

Comments:

ONLY WORKERS BASED IN A RESIDENTIAL, SCHOOL OR HEALTHCARE SETTING SHOULD COMPLETE THIS SECTION

Your GP or Occupational Health Provider may be able to provide you with the necessary documented evidence. (Please be aware some GP`s may charge for this service).

	Yes	No
Have you ever had Chicken Pox?	☐	☐
Have you ever had the Chicken Pox vaccination? If yes, please provide documented evidence.	☐	☐
Have you ever had the MMR vaccine? If yes, please provide documented evidence.	☐	☐
Have you ever had a course of Hepatitis B vaccine? If yes, please provide documented of the vaccine and / or immunity.	☐	☐
Do you have a TB Scar on your upper arm?	☐	☐

All applicants should read the following statement then sign and date the declaration

DECLARATION

I certify that the answers on this form are, to the best of my knowledge, correct. I understand that giving false or withholding information could affect the terms of my contract and may lead to my dismissal. I am prepared to be seen by the Occupational Health Nurse/Doctor, if necessary.

Signature of Applicant:……..……Date:……..……

To be completed by Occupational Health:

Fit to work ☐ Fit to work with advice (see comments) ☐ Referred to Physician ☐

Comments

……

……

Nurse/Admin Assistant assessing questionnaire: ……..

Signature: ……..Date:…….. ……

This form should be returned in a sealed envelope to:

Employee Health and Wellbeing Unit
Ground Floor
Centenary Square
Bradford
BD1 1HY

Eyesight Form

(Only required for posts that include vocational driving)

If your role is to incorporate transportation of the public it is a requirement of Bradford Metropolitan District Council that you meet the DVLA group 2 guidelines (outlined overleaf). Please take this form to your optician for completion and return with your health declaration form or as soon as possible.

PLEASE NOTE THAT YOU WILL BE REQUIRED TO MEET ANY CHARGE INCURRED FOR THE COMPLETION OF THIS FORM

Your details (please print):

Name:	**Post applied for:**	**Telephone No:**	**Date of Birth:**

For Optician's Use

Snellen's Test or Equivalent

	Right Eye	**Left Eye**	**Binocular**
Unaided	6/	6/	6/
Aided	6/	6/	6/

I certify: -

1. That the visual standards of the above named is **within / not within*** the DVLA Group 2 standards outlined overleaf

2. The above named has undergone corrective eye surgery **Yes / No***

3. I have examined evidence of identity e.g.
(a) Passport (b) Other ID with Photograph* (state) ……..……

* Delete as appropriate

Signed (Optician): Test Date: ……

(This section must be signed in the presence of the optician)

Signed (Applicant)

Optician's Stamp

DVLA Group 2 Guidelines

ACUITY	Applicants are unacceptable if the visual acuity, using corrective lenses if necessary, is worse than 6/9 in the better eye or 6/12 in the other eye. The uncorrected vision in each eye must be at least 3/60
CATARACT	Must be able to meet the above acuity requirement. In the presence of cataract, glare may prevent the ability to meet the plate requirement, even with appropriate acuities.
MONOCULAR VISION	Applicants are unacceptable if there is complete loss of vision in one eye or corrected vision is less than 3/60 in one eye.
VISUAL FIELD DEFECTS	Normal binocular field of vision is required.
DIPLOPIA	Applicants are unacceptable
NIGHT BLINDNESS	Group 2 acuity and field standards must be met - cases will then be assessed on an individual basis.
COLOUR BLINDNESS	No restriction
BLEPHAROSPASM	Consultant opinion required. If mild driving can be allowed subject to satisfactory medical reports.

Source - DVLA 'At a glance Guide to the current Medical Standards of Fitness to Drive' December 2011 (incorporating April 2012 amendments).

Website: www.dvla.gov.uk accessed May 2012