



Declaration of Health

PLEASE READ THE INSTRUCTIONS BEFORE COMPLETION

In order to process your application for Merco Recruitment Agency, standard health checks and documented evidence is required and needs to be enclosed within the attached questionnaire.

Our aim as an Occupational Health Team is to ensure that you comply with the Department of Health immunisation checks to enable you to work within your placements and to ensure if required adjustments will be made for your placements of work.

Please complete this form ensuring that all the questions are answered with relevant documentation which you can get from you current Occupational Health Provider or your GP and return it in the enclosed envelope as soon as possible.

To work as a Doctor/Nurse/Healthcare worker it is mandatory to have the following vaccination criteria:

1. **Hepatitis B** – Satisfactory evidence of having had or starting a course of vaccine or a Laboratory/Occupational Health report stating the individual's hepatitis B status.
2. **Varicella (Chicken Pox/ Shingles)** – a copy of a blood test result to show immunity is required if you have never had either of these two diseases.
3. **MMR – Mumps, Measles and Rubella (German Measles)**
Satisfactory evidence of protection would include documentation of having received two doses of MMR, or Positive antibody tests for mumps measles and rubella (Please Note Doctors only require Mumps).
4. **Tuberculosis TB** – Documented evidence of having had a BCG or Heaf test or Mantoux test with results. Or proof of immunity – either a clearly visible BCG scar. Your current Occupational health Provider can confirm this on documentation for you. If you do not have any evidence / scar (or inconclusive) evidence of prior BCG vaccination, a Mantoux tuberculin skin test (Or interferon-gamma test) will be arranged to be performed.

For all Exposure Prone Procedures (EPP Workers)

It is Department Health recommendations and best practice that new healthcare workers are not carriers of the HIV, Hep B or Hep C viruses. Applicants must therefore also provide a United Kingdom Laboratory report, confirming validated samples and performed within the last 6 months if you have not been working within the NHS, for HIV antibody, Hepatitis B Surface Antigen (Carrier Status) and Hepatitis C Antibodies. All people working within the NHS environment we will accept validated immunity checked results if over 6 months old.

Exposure Prone Procedure groups include: e.g. Doctors, Midwives, Theatre Staff, Operational Department Assistants or Operational Department Practitioners and A&E staff.



Please complete all sections of this form. If you answer yes to any questions you must give full details. Answering “yes” to any of these questions will not necessarily exclude you from your proposed job placement. Failure to complete this form and not including relevant documented evidence may result in delaying your application for this safety critical role.

ALL SECTIONS TO BE COMPLETED BY APPLICANT

SECTION 1

Surname:		Forename:	Title:
Gender:		DOB: ____/____/____	
Job role applied for			
Home Address			
		Post Code:	
Mobile telephone no:		Home telephone no:	
Email address:			

SECTION 2 – Declaration

You must answer all questions in order to provide a health assessment of your suitability for your proposed safety critical job role. Without this information, your application will not be processed any further. The Occupational Health Adviser / Nurse may require further information, if necessary from your GP or Specialist, once we have obtained your consent. All health information will be kept in strict confidence within the Merco Recruitment Agency your signature below is your consent for the agency to keep your health records. The information in this questionnaire will be screened by Choice- Occupational Health Services and used as a record of information about your health at the time of application.

I hereby declare that all medical information given in this document by me to Choice-- Occupational Health Services is true and accurate to the best of my knowledge, and I understand that if any of the information is incorrect, false, or if there is any other omission, It could result in disciplinary action being taken.

****Please sign below when you have read, understood and accepted this declaration***

FAILURE TO SIGN THIS DECLARATION WILL INVALIDATE THIS QUESTIONNAIRE AND WILL SUBSEQUENTLY DELAY YOUR APPLICATION FOR WORK.

Signature: _____ Date: _____



SECTION 3

To enable us to ensure that any reasonable adjustments are made in your working environment the following questions need to be answered. Please give further details if answering yes to any questions and please continue onto a separate sheet as necessary:

		YES	NO	DETAILS
1	Do you regard yourself as having a disability Or do you suffer from a long-term illness that may affect your proposed placement, Kindly give details. This will help us comply with the provisions of The Disability Discrimination Act 1995. We are committed to making reasonable adjustments to help people with disabilities to support and enable them to fulfil the placement.			
2	Do you think that you are psychologically and physically fit for the job role applied for?			
3	Do you suffer with Diabetes?			
4	Do you have any heart or circulatory disorders?			
5	Do you suffer from asthma, chronic bronchitis or any other chest condition?			
6	Do you suffer with any mental illness?			
7	Have you ever had a drug or alcohol problem?			
8	Do you suffer with blackouts or epilepsy?			
9	Do you suffer with any musculoskeletal issues?			
10	Have you ever had treatment for tuberculosis? What was the result?			
11	Have you ever suffered from chicken pox or shingles			

PLEASE ENCLOSE COPIES OF PROOF OF VACCINATION and COPIES OF TEST RESULTS. PLEASE SEE INSTRUCTIONS PAGE ONE OF THIS FORM.

(FOR EPP WORKERS THESE MUST VALIDATED SAMPLES AND BE OFFICIALLY STAMPED BY AN OH DEPT, GP OR A UK LABORATORY).



Please Complete if documentation cannot be obtained as proof of evidence of having had a BCG.

TB Declaration Form

This form is to be completed by an Occupational Health Nurse or is documented from another Occupational Health Department/GP surgery or Chest Unit if documentation cannot be obtained as proof of evidence of having a BCG.

Name:

Date of Birth:

Post:

BCG Scar (please answer yes or no):

Site of Scar:

Signed

Date
