YOUR WORLD HEALTHCARE® IRELAND
Supplying Healthcare Professionals

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New Employee Medical Questionnaire

PLEASE READ – *Once completed, there are three options to submit this application:*
1. Select 'send file' and follow the instructions.
2. 'Print to PDF' to save the information and email to ireland@ywrec.com
3. If your computer does not have these options, please print a hardcopy and send it to us by mail.

CONFIDENTIAL
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 and may need to be seen by an occupational health advisor or physician. Your record will be held on file for a short period of time and may be subject to audit. Your file may also be used to cross referenced should be registered on our system by one employer.

Personal Details

Title:	Surname:
First name:	Middle name(s):
Date of birth:	Home tel:
Work tel:	Mobile:
Home address	**GP address**
House name or no:	House name or no:
Street:	Street:
Town:	Town:
County:	County:
Postcode:	Postcode:
Country:	Country:

Medical History (all staff groups complete this section)

Do you have any illness/impairment/disability (physical or psychological) which may affect your work?	○ Yes ○ No
Have you ever had any illness/impairment/disability (physical or psychological) which may been caused or made worse by your work?	○ Yes ○ No
Do you think you may need any adjustments or assistance to help you to do the job?	○ Yes ○ No
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	○ Yes ○ No

If you have indicated yes to any of the above question's you must provide further details, failure to do so will result in the form been returned/rejected. Additional information:

Tuberculosis

Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2006)

Have you lived continuously in Ireland for the last 5 years?	○ Yes ○ No

If you have answered NO to the above, please list all of the countries that you have lived in/visited over the last 5 years, including duration of stay and dates i.e. Ireland March 2011 to July 2011

Have you had a BCG vaccination in relation to Tuberculosis?	○ Yes ○ No

If you answered yes, please state when:

Tuberculosis continued

Do you have any of the following?	
A cough which has lasted for more than 3 weeks	○ Yes ○ No
Unexplained weight loss	○ Yes ○ No
Unexplained fever	○ Yes ○ No
Have you had tuberculosis (TB) or been in recent contact with open TB	○ Yes ○ No
If you have answered yes to any questions above, please provide additional information below:	

Chicken Pox or Shingles

Have you ever had chicken pox or shingles? (please tick)	○ Yes ○ No
If yes, please specify the date:	

Immunisation History

Have you had any of the following immunisations?			Please date:
Triple vaccination as a child (Diptheria/Tetanus/Cough)	○ Yes	○ No	
Polio	○ Yes	○ No	
Tetanus	○ Yes	○ No	
Hepatitis B (please specify details below)	○ Yes	○ No	

Course:	1.	2.	3.
Boosters:	1.	2.	3.

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 and Measles
Hepatitis B	You must provide a copy of the most recent pathology report showing titre levels of 100lu/l or above
Proof of Immunity EPP Candidates Only *(please send the following)*	
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).

Exposure Prone Procedures

Will your role involve Exposure Prone Procedures? (please tick)	○ Yes ○ No

Declaration

The information supplied is true to the best of my belief. I agree to inform my employer of any health problems so that my health and safety can be protected whilst at work.	
Signed:	
Print name:	Date: