

# WORKFORCE GROUP

## PRE-EMPLOYMENT MEDICAL QUESTIONNAIRE

**\* \* \* CAUTION \* \* \***

**WHEN COMPLETED, THIS DOCUMENT CONTAINS CONFIDENTIAL MEDICAL INFORMATION**

### **GUIDANCE NOTES FOR RECRUITING OFFICER**

1. The recruiting officer or someone familiar with the duties of the post must complete "Job Information" in Section 1 on page 2, before copies are sent to successful candidates.
2. Where the answer to any of the questions in the Job Demands sub-section is "YES", please provide information on the specific activities, tasks and/or materials involved, including an indication of its importance in the person's work. The Workforce Group (WFG) Medical Adviser requires this information to help assess fitness for employment and plan services.
3. Once the Job Information Section has been completed, a copy of the whole form should be sent to all successful candidates. Who should be instructed to complete and scan the questionnaire to the WFG Medical Adviser at [dr.chiji.onwuchekwa@vorchehealth.com](mailto:dr.chiji.onwuchekwa@vorchehealth.com).

### **INFORMATION FOR SUCCESSFUL CANDIDATES**

1. **Section 1:** If Section 1 has not been completed, please contact your recruiting officer as soon as possible. If any of the asterisked items under Job Demands is checked, you may be required to attend the Company occupational health clinic for an assessment, to complete the pre-employment screening. You will be given appropriate instructions *after* the receipt of your form.
2. **Confidentiality:** All information provided on your health will be treated as confidential and will only be seen by the WFG Medical Adviser. The information you provide will be used to give an opinion about your fitness for employment and help the Medical Adviser to protect your health at work.
3. **Completing the Questionnaire:** You must complete Sections 2, 3 and 4 of this Form. You must also read and sign the declarations in Section 5.
4. **Medical Fitness:** If you have any doubts about your medical fitness to carry out the job, you are advised to contact your personal doctor for an assessment before resigning your present post.
5. **After completing the Questionnaire:** Scan and forward it to the WFG Medical Adviser at [dr.chiji.onwuchekwa@vorchehealth.com](mailto:dr.chiji.onwuchekwa@vorchehealth.com). The Medical Adviser will contact you to arrange an assessment as appropriate, after your questionnaire has been received.
6. **Further information:** If the Medical Adviser requires further information about your health, you will be contacted.
7. **Disabilities:** If you consider that you have a disability that may affect you in your work, kindly state this on the form. The Medical Adviser will then be able to assess and advise on what adjustments or assistance would be needed to enable you do the job.
8. **Medical Records:** Upon assumption of duties, this questionnaire will form the basis of your Occupational Health record, ownership of which is held by the Company Medical Adviser only.
9. **Policy Information:** The information obtained in the completion of this form is used to help determine whether an individual assigned to a job with duties that may be considered arduous or hazardous, can carry out those duties in a safe and efficient manner that will not unduly risk aggravation, acceleration, exaggeration, or permanently worsening pre-existing medical condition(s). Your submission of this information is **MANDATORY**. Failure to complete this form according to instructions may result in a delay in processing or inability to assign you to the job.

Name of Candidate: \_\_\_\_\_ Date: \_\_\_\_\_ 1

*Surname*

*First Name*

*Middle Initial*

**Section 1: Job Information** (to be completed by Recruiting Officer or Designee)

<b>Candidate's Name</b> <i>(Last; First; Middle Initial):</i>	<b>Proposed Start Date:</b>
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Job Details			
<b>Job Title:</b>	<b>Department:</b>	<b>Section:</b>	
<b>Usual Hours of Work:</b>	<b>Work Pattern</b> <i>(TICK ALL RELEVANT BOXES):</i>	<input type="checkbox"/> <b>Full-time</b>	<input type="checkbox"/> <b>Part-time</b>
		<input type="checkbox"/> <b>Common Hours</b>	<input type="checkbox"/> <b>Shift Hours</b>

Job Demands <i>(TICK ALL RELEVANT BOXES)</i>			
Physical Demands	Environmental Demands	Work Location	Other demands
<input type="checkbox"/> Deskwork	<input type="checkbox"/> Noise*	<input type="checkbox"/> Office	<input type="checkbox"/> Management of Staff
<input type="checkbox"/> Computer Work	<input type="checkbox"/> Dust or Fumes*	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Food Handling*
<input type="checkbox"/> Operating Machinery	<input type="checkbox"/> Chemicals	<input type="checkbox"/> Factory Floor	<input type="checkbox"/> Regular Night Work
<input type="checkbox"/> Standing	<input type="checkbox"/> Biohazards	<input type="checkbox"/> Workshop	<input type="checkbox"/> Need for Accurate Color Vision*
<input type="checkbox"/> Lifting/Carrying	<input type="checkbox"/> Work at Height e.g. on ladders	<input type="checkbox"/> Boiler/Generator House	
<input type="checkbox"/> Heavy Physical Work*	<input type="checkbox"/> Work in Confined Space	<input type="checkbox"/> Mobile Around Site	
<input type="checkbox"/> Driving*	<input type="checkbox"/> Very Cold or Hot Conditions	<input type="checkbox"/> Outdoors/Fieldwork	
	<input type="checkbox"/> Ionizing and Non-ionizing Radiation	<input type="checkbox"/> Offsite/Travel Abroad	

**Provide further details for all items ticked** *(continue on a separate sheet if necessary)*

<b>*Heavy Physical Work</b>	Involves lifting objects weighing up to 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more.
<b>*Driving</b>	Includes use of mechanized pallet trucks, forklifts etc.
<b>*Noise</b>	Tick only where applicant will be exposed to noise levels of 85dB and above
<b>*Dust or Fumes</b>	Tick only where applicant will be exposed to dust or fumes
<b>*Food Handling</b>	Includes handling drinks or wrapped food items e.g. packaged sandwiches & biscuits
<b>*Accurate Color Vision</b>	Tick only where accurate vision is essential to the job i.e. where color perception is necessary to undertake tasks or required for the safe operation of machinery etc.)

**Name of Candidate:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*Surname First Name Middle Initial*

**Section 2 Personal Details (TO BE COMPLETED BY THE CANDIDATE)**

<b>Your Name</b> <i>(Last; First; Middle Initial, Title):</i>		
<b>Address:</b>	<b>Date of Birth:</b>	<b>Age:</b>
<b>Email Address:</b>	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Phone No. 1:</b>	<b>Phone No. 2:</b>	<b>Marital Status:</b>

**Section 3 Health Information (TO BE COMPLETED BY THE CANDIDATE)**

Read carefully and answer **EVERY QUESTION** to the best of your knowledge. If you answer **YES**, **further details** must be provided. Failure to do so will result in a delay in processing your contract. Incomplete forms will be **RETURNED** and will delay the issuing of your contract of employment

	Yes	No
1. Have you ever had a health condition that may have been caused by work?		
2. Do you have any health condition that you think may affect your performance or safety at work		
3. Do you have any problems with hearing		
4. Do you have any problems with your eyesight (not corrected with spectacles/contact lenses)?		
5. Do you have any skin problems e.g. eczema, psoriasis, recurrent skin infections (boils), allergic rashes?		
6. Have you ever experienced a fit (convulsion), blackout or faints		
7. Have you ever had any mental health problems, including anxiety, depression, nervous breakdown, stress, self-harm, eating disorder and addictions)?		
8. Do you have any health conditions that cause you difficulty with:		
	<ul style="list-style-type: none"> <li>• Sitting</li> <li>• Standing</li> <li>• Moving around</li> <li>• Bending, lifting or carrying</li> <li>• Working with a computer</li> <li>• Any of the work activities ticked in Section 1</li> </ul>	
9. Are you taking any medication (except for contraception), or are you under any form of treatment at the moment?		
10. Have you ever been admitted into hospital?		
11. Are you waiting for any investigations, treatment or admission to hospital?		
12. Have you consulted a doctor/GP/specialist in the last year?		
13. Have you been absent from work/study due to illness in the last two years? If yes, give details of the number of occasions, the reasons for, and duration of, each absence below.		
14. Do you have any disability or health condition not already mentioned for which you think you may require support or adjustment to do your job?		

**If you answered YES to any of the above please give further details** (type of problem, the effect it has on you, when it occurred, how long it lasted, whether it still affects you in any way)

**Section 4 Additional Questions (TO BE COMPLETED BY THE CANDIDATE)**

Please provide information and about the vaccines below and attach copies of your results were applicable. If you are not sure of the answers, kindly find them out from your family doctor.

<b>When was your:</b>	<b>Date</b>	<b>Result</b>
Last Tuberculosis immunity test (Heaf Test or Mantoux Test)?*		Grade _____
BCG vaccination?		Scar Size: _____ mm
Last Tetanus immunization booster?		
Last menstrual period? (females only)		

\*Please attach copy of laboratory report

**Section 5 Declaration (TO BE COMPLETED BY THE CANDIDATE)**

I have read the information for applicants in Sections 2, 3 and 4, and have answered all the questions to the best of my knowledge. I understand that should I conceal relevant information or provide deliberately misleading information about my health on this form, or at a pre-employment health interview, the offer of employment may be withdrawn or that my employment may be terminated.

NB: Before signing, make sure you have answered **ALL QUESTIONS** as instructed, providing details as required.

If any questions are answered "YES" in Section 3, kindly provide a daytime phone number in your personal information (Section 2) so that you can be contacted by the WFG Medical Adviser.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Name of Candidate:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*Surname First Name Middle Initial*