**HEALTH SERVICE EXECUTIVE**

**PRE-PLACEMENT HEALTH ASSESSMENT FORM FOR THE COVID-19 PERIOD OF RECRUITMENT**

**CONFIDENTIAL TO OCCUPATIONAL HEALTH DEPARTMENT**

***This form is available in larger font upon request***

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| ***Sections 1-2 to be completed by Manager*** |
| **Section 1:Details of post (this section to be completed by Manager – can be left blank if post not yet allocated):** |
| Post/Grade:Grade  | Department/Location: |
| Hours of work: | Start date: |
| Name of HR Officer: | HR contact details:  |
| Recruitment area: | Recruitment officer:Recruitment officer email address: |
| Name of manager:  | Manager’s contact details:  |
| **Occupational Fit Slip to be returned by Occupational Health Provider to:**  |
| **Section 2:Required duties and job description (attach a copy of the current job description & person specification)****To be completed by Manager** |
| Includes (tick all that apply):* YES Driving
* Working at height
* YES Regular VDU work
* Night working
* Food handling
* Other (please specify):
 | Exposure to (tick all that apply):* Noise (>80dBA)
* Cytotoxic drugs
* Ionising radiation
* Respiratory sensitisers
* Vibrating equipment
* Other (please specify):
 | Consists of (tick all that apply):* Contact with patients
* Patient moving and handling
* Inanimate moving and handling
* Invasive surgical or Exposure Prone Procedures (EPP)
* Work in confined spaces
* Other (please specify):
 |
| **Assessment of Post in line with HSE HR Circular 19/2008****Exposure Prone Procedure (EPP) Post** |
| **HSE HR Circular 19/2008 defines Exposure Prone Procedures (EPPs) as ‘those invasive procedures where there is a risk that injury to the health care worker may result in the exposure of the patient’s open tissues to the blood of the health care worker. These include procedures where the health care worker’s gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (e.g. spicules of bone or teeth) inside a patient’s open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times’****Effective July 2008 all staff hired, transferred or promoted into an EPP post will be required to provide evidence via Occupational Health service of their freedom from infection in line with Circular 19/2008. No appointment will be made in the absence of such evidence.****A full copy of Circular 19/2008 and detailed information on those categories of staff and procedures coming under the scope of the EPP definition is available from the Area Recruitment Unit.****If there is any doubt about whether the post you have identified above comes within the definition of an EPP post, expert advice should be sought from the Occupational Health Service:** |
| **Does the post above identified for filling come within the definition of an** **Exposure Prone Procedure (EPP) Post?*(Tick below as appropriate)****Please refer to HSE HR Circular 012/2009* Implementation of Recommendations of Report on The Prevention of Transmission of Blood Borne Diseases in the Health Care Setting (appendix 1 Definitions) before completing this section |
| **YES** **[x]**  | **NO** **[ ]**  |

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| **Job Title:** | **Location:** |
| ***Sections 2-6 to be completed by incoming Intern employee and returned via secure upload for processing to:*** UCC STUDENT HEALTH DEPARTMENT |
| **Section 1a: Information for prospective employees regarding confidentiality** |
| *All information on this form will be treated as strictly confidential by the Occupational Health Service, and/or Occupational or Student Health Service acting on their behalf, in accordance with the provisions of the Data Protection Acts 1998 - 2018. No personal or medical information will be disclosed to a third party on an individual identifiable basis without your consent. The purpose of the pre-placement health assessment is:** *To determine the prospective employee’s fitness to carry out the duties of the post and to assist the HSE in meeting its obligations under the Safety, Health & Welfare at Work Act 2005*
* *To ensure the HSE complies with the Employment Equality Acts (1998 & 2004) by advising on measures that may be required to enable the prospective employee to carry out the duties of the post and render regular and efficient service*
* *To form the basis of a confidential occupational health record. This occupational health record will be held separately from other employment records maintained by the HSE.*

*A recommendation regarding your medical fitness for duty will be issued to Human Resources.* |
| **Section 2a: Personal details** *Please type in all boxes* |
| Family Name:  | Family name at birth (if different): |
| First names: | Date of birth: |
| Gender: |  |
| Address: | GP Name and address: |
| Telephone number: | GP telephone number: |
| Email: | GP email: |
| University:  | Student Health Service:  |
| **Section 3: Sickness absence** |
| *Have you lost significant time (> 4 weeks) from work or education due to sickness absence in the past two years?* ***Please select****:*[ ] **No** *If No: Proceed to* ***Section 4 below*** |
|  [ ]  **Yes** *If Yes: Please provide the following information:* ***Please type in all boxes*** |
| **Dates of absence** | **No of days absent**  | **No of occasions** | **Reason for absence** |

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| **Section 4: Immunity and immunisation status** |
| ***Clerical or administrative staff who do not have patient contact or contact with laboratory samples are not required to complete this section*** ***Healthcare workers with patient contact******are required to provide information relating to their immunity to:*** |
| * *TB*
* *mumps*
* *measles*
 | * *rubella*
* *varicella*
* *hepatitis B (anti-HBs).*
 |
| ***If you are not sending this form to your own University’s Student Health Service, you must attach a completed immunisation/vaccination certificate from your current Student Health Service and copies of previous laboratory test results if available****. Please also attach any other relevant vaccine records. Failure to provide this information may lead to a delay in health assessment that could affect your start date.* Healthcare workers with patient contact who may be involved in Exposure Prone Procedures (EPP) are required to submit evidence of non-infectivity to hepatitis B and C. If you are not sending this form to your own University’s Student Health Service, please provide a copy of your laboratory test results including the following information:Hepatitis B core antibody (Anti-HBc)Hepatitis B surface antigen (HBsAg)Hepatitis C antibody*These tests must be carried out on identified validated samples (IVS). Only results from an Irish or UK occupational health service that has confirmed the identity of the person by checking appropriate photographic ID e.g. passport, driving license or a photographic ID card will be accepted. For International recruitment, please refer to International recruitment documentation. Your consultant or manager will be advised that you cannot undertake EPP until all the requisite information has been received. If you are aware that you have any infectious disease or other health related condition that may impact upon your work, you have a responsibility to discuss this with the Occupational or Student Health Professional.***Please Select:****Are you uploading your immunisation/vaccination records and laboratory results with this form?** [ ]  No. Immunisation records and lab results are already on file in UCC Student Health. [ ]  Yes. Immunisation records and lab results are not on file in UCC Student Health (Non-UCC graduates only) |

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| **Section 5: Health and ability declaration** |
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|  **Have you suffered from tuberculosis (TB)\* Please select:**Within the past 12 months: **Please select**:* Has a family member or close contact has been treated for TB
* Have you had a cough for more than three weeks
* Have you coughed up blood
* Have you suffered unexplained weight loss
* Have you suffered from night sweats or fever
* Have you visited a foreign country for more than one month within the last two years\*

(Please enter the name of the country(ies) and the duration of visit: **Please Type name of country(ies)/duration**: ( )\* This information is required to determine appropriate screening and management of those who have spent time in countries with a high incidence of TB (40/100,000 cases notified per year). HPSC Guidelines on the Prevention and Control of Tuberculosis in Ireland (2010).**Please select as appropriate**: I have a BCG scar [ ]  Yes [ ]  No If ‘Yes’ please select the location: Right upper arm [ ]  Left upper arm [ ]  Other: | [ ] Yes[ ] Yes[ ] Yes[ ] Yes[ ] Yes[ ] Yes[ ] Yes | [ ] No[ ] No[ ] No[ ] No[ ] No[ ] No[ ] No |

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***Please select ONE of the below boxes:***[ ]  I am not aware of any health condition or disability that might affect my ability to undertake effectively the duties of the position that I have been offered. **PLEASE GO TO SECTION 6.**[ ]  I do have a health condition or disability that might affect my ability to undertake effectively the duties of the position that I have been offered, and that might require special adjustments to my work or my place of work.  **PLEASE ANSWER THE QUESTIONS BELOW BY SELECTING THE APPROPRIATE ANSWER:** |
| * Have you had a medical condition or operation in the past five years?
* Are you receiving treatment (including tablets and injections but excluding oral contraceptives or HRT) *include self-medication, physiotherapy, chiropractic treatment, psychological counselling or other support?*
* Have you suffered a work-related illness or injury, or given up work due to ill health?
* Do you have an impairment/disability (including intellectual disability) (including visual impairment, hearing impairment, dyslexia, dyspraxia etc)?
* Have you received work adjustments during previous employment/education (special equipment, access, mobility, restricted duties, shift adjustment etc)
* Have you suffered back, neck, joint or muscle problems?
* Have you suffered from skin problems, allergies and/or immune disorders
* Have you suffered from a mental disorder (including depression, anxiety, self-harm, eating disorder, psychological or emotional problems)?
* Have you had a drug or alcohol abuse problem or other addiction
 | [ ]  Yes[ ]  Yes[ ]  Yes[ ]  Yes[ ]  Yes[ ]  Yes[ ]  Yes[ ]  Yes[ ]  Yes | [ ]  No[ ]  No[ ]  No[ ]  No[ ]  No[ ]  No[ ]  No[ ]  No[ ]  No |
| **If you selected Yes as the answer to any of the questions above, please advise and type details in the text box below:*** When and for how long you had the problem
* What type of treatment you received
* Whether you were admitted to hospital, unable to work or prevented from carrying out your normal activities because of the problem
* Whether the condition affects you now in any way
 |
| **Section 6: Declaration by applicant** |
| ***Please read the declaration below carefully****I declare that the information I have given is true and complete to the best of my knowledge and that I have not withheld any material facts. I understand that I am responsible for the accuracy of my statement. I understand, accept and confirm the entitlement of the Health Service Executive to reject my application or terminate my employment (in the event of a contract of employment having been entered into) where I have omitted to furnish any information relevant to this health assessment or where I have made any false statement or misrepresentation relevant to this health assessment.**I understand that the medical information given by me is confidential to the Occupational Health Service, and/or Occupational or Student Health Service acting on their behalf, and will not be disclosed to any other person without my explicit consent. A report on my fitness for the position offered will be given to management along with any recommendation for work adjustments that may be appropriate.**I understand that I may be required to undergo an assessment by Occupational Health if considered necessary. I agree to a relevant Occupational Health record being kept for the duration of my employment. I accept that I have an ethical and professional obligation to inform the Occupational Health service, in confidence, if I am HIV positive/hepatitis B positive/hepatitis C positive in accordance with Department of Health guidelines.**Signed: Date:*  ***Please insert your electronic signature above*****PLEASE REVIEW AND CHECK YOUR ANSWERS AND ENSURE YOU HAVE COMPLETED ALL SECTIONS.** **PLEASE SAVE YOUR CHANGES AND UPLOAD THE FILE VIA THE MICROSOFT FORM LINK E-MAILED TO YOU BY DR. BYRNE****PLEASE DO NOT SEND THIS FORM VIA E-MAIL.** |

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| **Section 8: Occupational Health use only** |
| Screened by: | Date: |
| OHP/OHA: | Result: |
| Comments |  |
| **Fit Slip to be returned to:** |  |