

PRE EMPLOYMENT HEALTH ASSESSMENT

The information you are required to provide will remain confidential to the WH&S and Injury Management Unit.

Please complete all sections of this document.

Any information not provided slows down progression of your paperwork.

If you have any difficulties completing this form or wish to discuss any issues in a confidential setting, please contact Nerida Sokolich (Employment Screening Coordinator) on 07 5590 6392 or 0438 259 284.

PART A: PERSONAL DETAILS

Surname: _____	First Name/s: _____
Former name (if applicable): _____	Date of Birth: ____/____/____ M / F (circle)
Address: _____	Postcode: _____
Phone No (Home): _____ (Mobile): _____	(Work): _____
E-mail: _____	
Present Employee of NNSWLHN: Yes / No	Employee Number: Yes / No Number: _____
Have you attended a pre-employment health assessment for NNSWLHN in the last 12 months? Yes / No	

PART B: POSITION DETAILS

Position applied for: _____	Recruitment No: _____
Hospital/Facility: _____	Ward/Dept: _____

PART C: GENERAL HEALTH SCREENING

1. Have you been involved in any motor vehicle accidents resulting in personal injury? **Yes / No**

1a. Please give details of motor vehicle accidents or Third Party claims relating to injuries sustained:

Date of injury: _____ Insurer: _____

Nature of Injury/Illness:

2. Have you ever lodged a claim for workers compensation? **Yes / No**

If Yes, Please give details including date, injury and employer at the time of claim:

Date of Injury: _____ Employer: _____

Nature of Injury/ Illness:

3. Have you suffered back pain or strain injury (including back surgery)? **Yes / No**

If yes, please give details:

4. Have you suffered from shoulder, neck or arm pain or strain? If yes, please give details: **Yes / No**

5. Have you suffered from hip, knee or ankle pain? If yes, please give details: **Yes / No**

6. Have you had a full medical clearance for any injury identified in questions 1 to 5? **Yes / No**

Please give details:

7. Are you receiving any ongoing treatment for injuries identified in questions 1 to 5? **Yes / No**

If Yes, please give details:

8. Do you suffer from any medical condition (including physical, psychiatric, psychological) for which you are receiving treatment? **Yes / No**

If Yes, please give details:

8. Have you ever had or do you have, any of the following?

	YES / NO	If Yes, is it current?
Lower back, neck or thoracic spinal pain?	Yes / No	Yes / No
Sciatica?	Yes / No	Yes / No
Wrist or elbow pain or weakness?	Yes / No	Yes / No
Tenosynovitis, carpal tunnel or RSI?	Yes / No	Yes / No
Arthritis, rheumatism or painful joints or other musculoskeletal pain?	Yes / No	Yes / No
Any broken bones or torn cartilage?	Yes / No	Yes / No
Scars/deformations which may restrict physical movement?	Yes / No	Yes / No
Hernia?	Yes / No	Yes / No
Diabetes?	Yes / No	Yes / No
Epilepsy, dizzy/giddy/fainting spells, blackouts or neurological disorder?	Yes / No	Yes / No
Mental health condition including severe anxiety and depression?	Yes / No	Yes / No
High blood pressure, chest pain or heart or circulatory trouble?	Yes / No	Yes / No
Asthma, chronic bronchitis or other chest problems?	Yes / No	Yes / No
Auto Immune Disease or on immunosuppressant medication?	Yes / No	Yes / No
Nail infections, or chronic skin infections?	Yes / No	Yes / No
Eczema, dermatitis, hives or other skin rashes or complaints?	Yes / No	Yes / No
Have you ever been diagnosed with latex allergy?	Yes / No	Yes / No
Allergic or adverse reaction to any medicines, vaccinations, insect bites, animal fur, bandaids, rubber and/or foods?	Yes / No	Yes / No
Any problems with vision or hearing?	Yes / No	Yes / No
Any other serious illness?	Yes / No	Yes / No
Current health problems, illness or injury related to any previous employment?	Yes / No	Yes / No

If you answered **YES** to any of the above conditions, please give details (eg year, diagnosis, treatment, medication etc):

PART D: PAST OCCUPATIONAL EXPOSURES

Have you been exposed to or monitored for any of the following?

	YES / NO	YEAR & PLACE
a. Cytotoxics	Yes / No	
b. Glutaraldehyde	Yes / No	
c. Ethylene oxide	Yes / No	
d. Asbestos	Yes / No	
e. Pesticides	Yes / No	
f. Lead	Yes / No	
g. Solvents	Yes / No	
h. Excessive noise or required to wear hearing protection	Yes / No	
i. Have you had previous hearing testing?	Yes / No	
j. Have you had previous health screening / medicals for exposure to asbestos or work-related dust?	Yes / No	

PART E: HEALTH DECLARATION

Please indicate your declaration by completing the questions below. Please note that by responding to these questions and uploading this document as part of your application, you are providing electronic declaration of the following statements:

I hereby declare that the above statements and answers are true and correct to the best of my knowledge. I have read the inherent requirements for the position I am applying for and I understand and can fulfil these requirements.	Yes / No
I agree to the release of medical information to my prospective employer that directly relates to my ability to carry out the tasks adequately and safely in this position.	Yes / No
I am aware that any false or misleading statements may impact on my appointment or continued employment with Northern NSW Local Health Network.	Yes / No

Print Name: _____

Signature of Applicant: _____

Employee Number (if known): _____

Date: ___/___/___

PART F: REFERRAL

You may be required to undertake a pre-employment functional assessment. If this is required, you will be advised by e-mail.

IMPORTANT INFORMATION:

The pre-employment functional assessment DOES NOT determine your suitability for employment. This assessment is only one component of the overall recruitment process. It is not the only factor determining whether you are successful in gaining employment.