CONFIDENTIAL

Occupational Health Screening Questionnaire for Staff & Postgraduates- Guidance

Section A should be completed by either HR or your Supervisor/Admissions Tutor – if this section is incomplete, please check with them, as we will have to return this sheet if there is incomplete information which will result in a delay to your form being processed.

Please start by completing **Section C** and go onto each of the following questions in **Section C**

In the case of any positive answers, please provide any additional information in the space provided (or attach details if the space is insufficient).

Following this, please complete the vaccination history (**Section D**) which will be

applicable to you if your role will involve working in a clinical/laboratory setting or if you have exposure to human/animal tissue.)

Before you submit the form to us, ensure that you have completed the declaration (**Section E**).

The completed form should then be sent to Occupational Health Services and returned in the envelope supplied to the relevant site:

Oxford Road Campus:
182-184 Waterloo Place, Oxford Road, Manchester M13 9GP Tel: 0161 275 2858,
waterlooocchealth@manchester.ac.uk

Sackville Street Campus:
B22 The Mill, Sackville Street, Manchester M13 9PL Tel: 0161 306 5806,
millocchealth@manchester.ac.uk

You can be assured that the information you provide will remain confidential to Occupational Health Services.

For your own health and safety and so that the University can comply with legislation, it is important that your answers are accurate and that you do not withhold any facts.

Depending on your answers, and the nature of your proposed work, you may be asked to attend further screening before we can confirm your medical fitness.

Please Tick:

University Employee *(including PGs who are employed)*: ☐ **Postgraduate Student:** ☐

Have you attended Occupational Health Services before? Yes / No?

A To be completed by Human Resources, Admissions Tutor or Supervisor BEFORE sent to Candidate.

Title:	**Surname:**	**Employee ID No:**
Sex: M/F:	**First Name:**	**Date of Birth:**
Proposed Job Title/ Course: *(for the position relevant to this form)*		
Proposed Start Date:		
Department/ Faculty/ School: *(the position relevant to this form)*		
Building Name		
Length of Course (Postgraduates Only):		
Supervisor/ Line Manager's Name:		**Contact Tel No**:
HR Manager / PG Administrator's Name: *(person requiring notification of questionnaire received)*:		**Contact Tel No:**

Please indicate (✓) in the box if the proposed job, course or research will involve any of the following:

Lab work Chemicals:	☐	Clinical work:	☐	Manual handling:	☐	Working at height:	☐
Lab work Biological Agents:	☐	Animal work:	☐	Food handling:	☐	Regular night work:	☐
Lab work Genetically Modified Organisms:	☐	Driving University vehicles:	☐	Regular use of a computer (DSE):	☐	Working in noisy environments:	☐
None mentioned above	☐						

B For Occupational Health Use Only	**Comments**	
Medically fit for job/ course (no further screening required):		
Medically fit for job/ course (further routine screening will be arranged due to the nature of the job/ course):		
Further screening required prior to any recommendations on medical fitness:		
Medically fit for job/ course subject to the following restrictions/ adjustments:		
Medically unfit for job/ course:		
Print Name:	**Signature:**	**Date:**

C Personal Details

Surname:		**First Name:**		**Title:**	
Date of Birth:		**Country of Origin**			

Permanent Address	**Term Time Address**
Dates resident here:	Dates resident here:
(1)	(2)
Tel No:	**Tel No:**
Mobile:	
Email: *(Please note, once you have started work./ study we will only contact you using your University email address)*	

General Practitioner's Name and Address *(The Doctor with whom you are/ will be registered for primary care in the UK)*
Tel No:

Employment History (if applicable)

Nature of Work	Employer	Start Date	Finish Date

	Yes	No
Have you ever had to finish or leave work on health grounds?		

If **Yes**, please provide further details:

Details of Previous Courses/ Study:

Name of College/University	Course	Start Date	Leaving Date	Degree

If you failed to complete the course, please provide details:

Your Health and Functional Capabilities:			**Yes**	**No**
1	**Do you have problems with any of the following:-**			
	a.	**Mobility?** e.g., walking, using stairs, balance:		
	b.	**Agility?** e.g., bending, reaching up, kneeling down:		
	c.	**Dexterity?** e.g., getting dressed, writing, using tools:		
	d.	**Physical Exertion?** e.g., lifting, carrying, running:		
	e.	**Communication?** e.g., speech, hearing:		
	f.	**Vision?** e.g., visual impairment, colour blindness, tunnel vision:		
If **YES** to any of the above, please give details (e.g., extent of impairment, how you manage, support needs):				

2.	**Have you ever required special arrangements at school or work to accommodate a disability or health problem? (e.g. special equipment, extra time in exams, part-time working).**	**Yes**	**No**
If YES please give details:			

3	**Do you have, or have you had, any of the following?**		**Yes**	**No**
	a.	**Chronic Skin Condition?** e.g., eczema, psoriasis.		
	b.	**Neurological Disorder?** e.g., epilepsy, multiple sclerosis.		
	c.	**Allergies?** e.g., latex, medicines, foods.		
	d.	**Endocrine Disease?** e.g., diabetes.		
	e	**Hep B/ Hep C/ HIV?**		
If **YES** to any of the above please give details (e.g. when condition developed, severity, effects and treatment):				

			Yes	**No**
4	**Have you ever been affected by:**			
	a.	**Sudden Loss of Consciousness?** e.g., fit or seizure:		
	b.	**Chronic Fatigue Syndrome?**(or similar condition):		
	c.	**Mental Health Issues?** e.g., anxiety, depression, phobias, OCD, nervous breakdown, personality disorder, over-dose or self-harm, drug or alcohol dependency:		
	d.	**An Eating Disorder?** e.g., bulimia, anorexia nervosa, compulsive eating:		
	e.	**An illness requiring more than two weeks' absence from school or work?**		
If **YES** to any of the above please give details:				

5	**Have you ever received treatment from a psychiatrist, psychotherapist or counsellor?**	**Yes**	**No**
If **YES** to any of the above please give details:			

		Yes	**No**
6	**Are you currently taking any medication or treatment?**		
If **YES** to any of the above please give details:			

		Yes	**No**
7	**Do you have any disability or health condition not already mentioned for which you think you may require support during your employment/ education or training?**		
If **YES** to any of the above please give details:			

8	**What is your height?**		**What is your weight?**	

D **This section is ONLY to be completed by those whose work will involve a clinical/ laboratory setting and/ or exposure to human/ animal tissue**

BCG (Tuberculosis):		
	Yes	**No**
Have you had Tuberculosis:		
Is there a family history of Tuberculosis?		
Have you lived or worked abroad for a period greater than 3 months?		
If **YES** please give details of: Date:		
Country:		
	Yes	**No**
Have you been vaccinated against Tuberculosis?		
If **YES** please give details of:		
Date of Tuberculosis vaccination (BCG):		
	Yes	**No**
Do you have a visible scar (usually located on the upper arm)?		
Have you had a recent chest x-ray?		
If **YES** please supply details of dates and location:		

MMR (Measles, Mumps and Rubella) / Varicella (Chicken Pox) Please specify:

I have had the following disease(s):	**Yes**	**No**	**Don't Know**	**I have received the following vaccinations:**	**Yes**	**No**	**Date Received:**
Measles:				Measles:			
Mumps:				Mumps:			
Rubella:				Rubella:			
				MMR:			
Chicken Pox:				Varicella:			

Hepatitis B:		
	Yes	**No**
Have you previously worked with human tissue, blood or bodily fluids?		
Have you ever been offered Hepatitis B vaccinations?		
If **YES** please provide the following dates and details:		

Date of 1st Dose	**Date of 2nd Dose**	**Date of 3rd Dose**	**Date of blood test**	**Result of blood test Iμ/l**	**Date of Booster**

Other:					
Vaccinations:	**Dates Of Vaccinations:**				
Pertussis (Whooping Cough)	1st	2nd	3rd		
Polio	1st	2nd	3rd	4th	Booster
Tetanus	1st	2nd	3rd	4th	Booster
Diphtheria	1st	2nd	3rd	4th	Booster
Meningitis C					
Other (specify)					

Please ensure that you have answered **ALL** of the questions and that **Section A has been fully completed** by an appropriate person **before you submit** this questionnaire to Occupational Health.

Your assessment cannot be completed until you do.

E

Data Protection Information:

If you join the University this questionnaire will form the basis of your Occupational Health (OH) record. If you do not join, your questionnaire will be destroyed.

- Records are held in confidence by Occupational Health Services. Section's A and B of this questionnaire are provided to your designated Human Resources Manager/Postgraduate Administrator in order to provide evidence of your fitness to work/study.

- No identifiable medical or other information you provide in confidence and contained in your Occupational Health record will be released by Occupational Health Services to anyone else without your consent being obtained.

- You may obtain access to your Occupational Health record by contacting Occupational Health Services.

- If you require further information contact

Oxford Road Campus:
waterlooocchealth@manchester.ac.uk
Waterloo Place, 182-184 Oxford Road, Manchester M13 9GP Tel No: 0161 275 2858

Sackville Street Campus:
millocchealth@manchester.ac.uk
B22 The Mill, Sackville Street, Manchester M13 9PL Tel No: 0161 306 5806

- The University of Manchester will not share your information with any third party. For further information of your rights to access data which we hold about you please contact the Records Management Office telephone 0161 275 8111 and e mail dataprotection@manchester.ac.uk

Declaration

I confirm that the information provided is true and accurate to the best of my knowledge. I accept that whilst the responses to the questionnaire are normally confidential to Occupational Health Services, in the event of it being subsequently shown that relevant medical information has been withheld, or misleading, Occupational Health Services reserves the right to notify Management and this could lead to the offer of employment/ course being withdrawn or later lead to disciplinary proceedings which may include dismissal.

I shall inform Occupational Health Services immediately should my medical circumstances change between the date signed and the completion of my course/ during employment.

I give my consent for my General Practitioner to provide the University Occupational Health Services with any medical information relevant to my application.

Name:	Signature:	Date:

Following consideration of your completed form it is possible that you will be asked to attend Occupational Health Services. This may be to enquire further into a medical condition, if considered appropriate to do so, or for medical surveillance in view of the nature of your job.

In the case of those involved with laboratory and clinical work it would be helpful to bring with you details of your vaccination history including serology where appropriate.

Thank you for completing the form