EMPLOYMENT HEALTH QUESTIONNAIRE

This health questionnaire is **confidential** to you and your appointing Manager. The information may be provided to your appointing manager for assessment and/or recommendations, and your permission for this will be sought. Information **will not** be given to anyone else without your written permission.

Please complete this form with as much detail as possible and attach any additional information you may have. Once completed, please return the form with your employment application.

The employment health questionnaire of successful applicants will be filed in their personal file held securely by their appointing manager for the duration of their employment. Employment questionnaires of unsuccessful candidates will be held disposed of by confidential shredding.

Surname:_____ First Name:_____

Address:_____ _____

Contact Phone No: _____ Female ☐ Male ☐

Proposed Job: _____

Appointing Manager: _____

Site: _____ Department: _____

Have you been employed by Hospice Taranaki in recent years: Yes ☐ No ☐

If yes, please identify the following: _____

Start Date:_____ End Date:_____ Surname Used: _____

Are you a New Zealand Resident? Yes ☐ No ☐

Have you visited or resided overseas in the last 2 years? Yes ☐ No ☐

If yes, please complete the following:

Place Visited or Resided In_____

When (Month and Year)_____

Duration of Stay_____

Past History

1. Have you ever had time off work as the result of an **illness** (physical or mental)? Yes ☐ No ☐

   If Yes - When: _____

   What for: _____

   Will this **illness** affect your ability to do the job applied for? Yes ☐ No ☐

2 Have you ever had time off work as the result of an **injury**? Yes ☐ No ☐

   If Yes - When: _____

   What for: _____

   Will this **injury** affect your ability to do the job applied for? Yes ☐ No ☐

3 Do you have or have you had in the past a Gradual Process Disease (Occupational Overuse Syndrome) that may affect your ability to do the job applied for? Yes ☐ No ☐

   If Yes – please explain: _____

_____

_____

4 Have you ever had an **ACC or other type of compensation claim** for an injury/illness including gradual process disease or a significant infection? Yes ☐ No ☐

   If Yes - When _____

   What for: _____

   _____

   Will this **ACC or other type of compensation claim** affect your ability to do the job applied for Yes ☐ No ☐

Present History

1. Do you have a history of Epilepsy? Yes ☐ No ☐

   If Yes - is this controlled? Yes ☐ No ☐

2. Have you ever been known to have a colour vision defect Yes ☐ No ☐

3. Do you have any visual difficulties eg do you wear glasses or contact lenses? Yes ☐ No ☐

   If Yes – please explain: _____

   _____

4. Do you have any hearing difficulties? Yes ☐ No ☐

   If Yes – please explain: _____

5. Do you suffer from any allergies? Yes ☐ No ☐

   If Yes - please explain: _____

   _____

6. Do you suffer from Latex sensitivity? Yes ☐ No ☐

   If Yes - please explain: _____

   _____

7. Do you suffer from any of the following? Yes ☐ No ☐

   Asthma Paronychia Dermatitis Eczema Psoriasis Skin Lesions

   If Yes - please circle those applicable and provide comments: _____

   _____

8. Are there any other conditions (including physical and mental) that may affect your job, tasks to be performed or your work performance or those of other people that we should be aware of?
   Yes ☐ No ☐
   If Yes - please explain: _____

   _____

9. Are there any disability needs that you require assistance with? Yes ☐ No ☐

   If Yes - please explain: _____

Exposure History

Have you ever been exposed (excessively or continuously) to the following?

Noise Yes ☐ No ☐

Chemicals Yes ☐ No ☐

Asbestos Yes ☐ No ☐

Please provide comments: _____

Other Work

Do you currently work for any other organisation and intend continuing this if you are successful in being appointed for this role? Yes ☐ No ☐

If Yes - please provide the following details:

Nature of Work: _____

Hours Worked: _____

Immunisation Status

Please complete the following table:

	Yes ✓	No ✓	Unsure ✓	Date and Status	Had Disease ✓
Hepatitis B					
Rubella					
Tuberculosis Mantoux/Heaf Test					
Tuberculosis BCG (Visible Scar)					
Poliomyelitis					
English Measles Morbilli					
Diphtheria					
Mumps					
Chicken Pox/Herpes Zoster (shingles)					
Tetanus (Primary Vaccination)					
Tetanus (Booster)					

Last Chest X-ray Date: ____/____/____

MRSA *(Methicillin Resistant Staphylococcus Aureus) – CLINICAL STAFF ONLY*

To prevent the inadvertent transmission of MRSA to Hospice Taranaki facilities, newly appointed clinical staff must be screened for MRSA (see over page for swab sites and notes) **if they have direct patient contact** and answer **yes** to any of the following questions:

1.	Are you a non-resident coming to New Zealand to work?	Yes ☐ No ☐
2.	Have you worked in or been a patient in a healthcare facility outside of New Zealand within the last six months?	Yes ☐ No ☐
3.	Have you worked in or been a patient in a New Zealand healthcare facility within the last six months?	Yes ☐ No ☐
	If Yes – please name the healthcare facility:_____	
4.	Have you had any chronic nasal or skin conditions eg exfoliative conditions, paronychia, dermatitis or sinusitis that may easily become colonised or infected with MRSA	Yes ☐ No ☐
5.	Have you previously been found to be colonised and/or infected with MRSA?	Yes ☐ No ☐

Required Swabs

- One swab from each of the three sites (see diagram below) if **not previously** colonised or infected with MRSA
- Three sets of swabs (a set is one swab from each of the three sites – see diagram below) collected at 24 hours intervals over three consecutive days (ie three sets in total) **if history of colonisation or infection with MRSA.**

Please Note

1 All swabs requested must be taken and reported after ceasing employment and before commencing work at Hospice Taranaki. You can go to your doctor, a medical clinical or laboratory for the swabs.

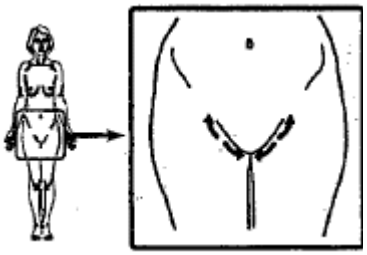
2 Hospice Taranaki does not accept any responsibility for any costs incurred in the screening or the treatment in the case of positive results.

3 Commencement of employment will be delayed until laboratory evidence of the absence of MRSA is obtained or until completion of appropriate treatment (if results were positive) **and** clearance to commence work is obtained from the Hospice Taranaki Risk Advisor. The employee will not be paid until they actually commence work.

Results must be marked “Confidential” and sent to: Medical Team Leader, PO Box 5122, Westown, New Plymouth 4343.

Nose
Use a single swab pre-moistened in transport medium and sample from well inside both left and right nostrils.

Groin
Use a single swab pre-moistened in transport medium and rub firmly several times of the left and right groin areas.



Other infected skin areas
Use a separate swab pre-moistened in transport medium to sample any other broken skin areas, especially any dermatitis or inflamed skin, seeping skin sores, crusted skin lesions, or any surface wounds.

Label each of the swabs with the site that is sampled.

APPLICANTS AUTHORITY TO ACCESS MEDICAL INFORMATION

Name _____*(Please print clearly)*

Proposed Position _____

I authorise the my appointing M to obtain any information, including medical information and claim cost information, held by the Accident Compensation Corporation (ACC), any other Insurance Company or any Medical Practitioner relating to any accident or gradual process claims that I have lodged, or may in the future lodge with ACC or an Insurance Company.

I agree that after consultation with me, my appointing Manager may contact my Medical Practitioner to obtain additional information regarding issues arising from my health assessment questionnaire.

I further agree to undergo a medical examination at the expense of Hospice Taranaki, if required.

SIGNED _____ DATE__ _____

Deliberate intent to mislead and/or supply false declarations to the questions contained in this document could lead to disciplinary action, which may include dismissal.

I have read and declare that to the best of my knowledge the information I have given in this document is true and correct in every aspect.

Signature _____ Date _____

Name *(Please print clearly)*: _____