

Pre-Employment Occupational Health Assessment (Otago)

The Southern District Health Board (Southern DHB) recognises that staff are its most important resource. All prospective employees must complete a pre-employment health questionnaire before an offer of employment can be made. This includes existing staff transferring positions within Southern DHB or former staff resuming employment.

You are required to provide the information requested on this form to:

- Assist us in meeting our obligations under the Health and Safety at Work Act (2015)
- Ensure you are fit to perform the duties of the position you have applied for
- Ensure your safety and the safety of others
- Establish a baseline for future health monitoring and health protection
- Identify the need for specialist occupational health service support

The information you provide will be received and reviewed by the Occupational Health Service and a recommendation regarding your health suitability for the position you have applied for will be given to the hiring manager. **We cannot progress your application until this form is returned.**

Your information will be collected and stored in accordance with the Privacy Act (1993), the Health Information Privacy Code (1994) and Public Records Act (2005). Should your application be unsuccessful, this form will be destroyed 2 years after the last date of action or when administratively no longer required (whichever is longer).

APPLICANT DETAILS	
Date:	NHI Number (if known):
Last Name:	First Name(s):
Previous Name(s):	Date of Birth:
Ethnicity:	Gender:
Residency Status:	VISA HOLDERS ONLY
Address:	Country of Birth:
	Date of Entry to New Zealand:
	Visa Status:
	GP Name / Medical Centre: This information is required to generate an NHI number
Mobile Number:	
Home Telephone:	
Email:	
Position Applied For:	Department/Service:
Hiring Manager:	Have you worked for the Southern DHB previously?
	If yes, approximately when:

OCCUPATIONAL HISTORY

Please provide a brief employment history giving consideration to any potential hazardous exposures you may have had during your employment.

Role	Employer	Occupational Exposures (e.g. asbestos, chemicals, cytotoxics, dust/fumes, noise/vibration, repetitive processes, radiation including UV, skin irritants/MRSA)	Dates of Employment (List most recent first)

Have you had any previous health monitoring?

If so, please specify what type (e.g. hearing, spirometry), where and when:

RISK-BASED HEALTH ASSESSMENT

Please refer to the position description to answer the following questions.

Section A – General Information

1. Have you had any injury or illness that resulted in you taking five or more consecutive calendar days off in the last five years prior to your application?

If yes, please specify:

2. Are you currently being treated for any illness or injury?

If yes, please specify:

3. Do you currently have an open ACC claim for an unresolved injury?

If yes, please specify:

4. Do you have any ongoing problems from previous injuries or work-related conditions?

If yes, please specify:

5. Have you ever experienced any sudden incapacitating events (e.g. asthma, diabetes, epilepsy, heart attack, migraine, stroke or other collapse)?

If yes, please specify:

6. Are you taking any sedating or other medication (prescription or non-prescription) which may impact on your ability to do your job?	
If yes, please specify:	
7. If your job involves shift-work, is there any medical reason why you may not be able to do this (e.g. epilepsy, mental health, other medical conditions, uncontrolled diabetes)?	
If yes, please specify:	
8. Is there any reason (e.g. health condition or religion) that would prevent you from wearing personal protective equipment or clothing (e.g. closed shoes, gloves, hearing protection, head protection, lead apron, masks, safety glasses)?	
If yes, please specify what equipment or clothing and why:	
9. Do you require any workplace modification or special equipment to perform the job you have applied for?	
If yes, please specify:	
Section B – Diabetes	
1. Do you have diabetes?	
If yes, please select those that apply:	
Type I	HbA1c under 60
Type II	HbA1c over 60
Diagnosis less than 10 years	Unacceptable highs and/or lows
Diagnosis more than 10 years	Complications of diabetes
Section C – Heart Disease	
1. Do you have heart disease or other cardiac conditions?	
If yes, please select those that apply:	
Cardiomyopathy	Hypertension – well controlled (including on medication)
Heart failure	Hypertension – suboptimal control, including on medication (BP 160 – 179 / 100 – 109 or higher)
Ischaemic heart disease	Uncontrolled atrial fibrillation (HR > 100 bpm)
Previous heart valve surgery	
Angina/chest pain, swelling in lower limbs, shortness of breath	
Section D – Immunocompromising Conditions or Medications	
1. Do you have any immunocompromising conditions (e.g. HIV infection, immune deficiency syndromes, organ transplants, rheumatoid arthritis)?	
If yes, please specify:	
2. Do you use any medications with the potential to compromise the immune system?	
If yes, please specify:	

3. Do you have chronic kidney/liver disease?	
If yes, please specify:	
4. Have you had a splenectomy?	
If yes, please state when:	
Section E – Cancer	
1. Have you ever had cancer(s)?	
	Active cancer
	Recovering from cancer (on chemotherapy or radiotherapy)
	Full recovery from previous cancer
Section F – Neurological	
1. Do you have any neurological conditions (e.g. cerebral palsy, multiple sclerosis or Parkinson's disease)	
If yes, please specify:	
2. Have you ever had concussion(s) or any other head injury?	
If yes, please specify:	
Section G – Respiratory Conditions	
1. Do you have any respiratory problems (e.g. asthma, chronic obstructive pulmonary disease, interstitial lung disease, recurrent bronchitis or pneumonia, shortness of breath)?	
If yes, please specify:	
Section H – Skin Integrity	
1. Have you ever experienced eczema, dermatitis, psoriasis or chronic skin condition/infection?	
If yes, please indicate the areas affected:	
Hands	Arms
Face	Neck
Other (specify):	
2. Are you currently being treated for any skin conditions?	
If yes, please specify:	
3. Do you have a latex allergy?	
Section I – Mental Health and Wellbeing	
1. Do you have, or have you had, any condition that has or may affect your ability to perform the job you have applied for (e.g. anxiety, depression, phobia, stress or enduring mental health conditions)	
If yes, is this ongoing?	
If this is ongoing, please specify:	
2. Are you receiving treatment (including medication)?	

3. Have you ever received treatment for alcohol or drug dependency?	
If yes, is this ongoing?	
Section J - Musculoskeletal	
1. Do you have any health issues that may affect your work or ability to take part in training e.g. CPR, moving and handling and restraint?	
2. Have you ever had a muscular, skeletal or nerve condition or injury (e.g. fractures, hernia, mild inflammatory joint conditions, osteoarthritis, sprains, strains or any gradual process injuries) that does, or may affect your ability perform the job you have applied for?	
If yes, please indicate the areas affected:	
Neck	Hands/Wrists
Shoulders	Elbows/Upper Arms
Back/Spine	Hips
Knees/Legs	Ankles/Feet
If you answered yes to any of the above questions in Section J , please provide further details:	
Section K – Exposures and Sensitivities	
1. Do you have any allergies, including anaphylaxis?	
If yes, please specify:	
2. Have you ever had health problems/allergic reaction (e.g. asthma, breathing difficulties, severe headache, skin rash) related to any substance?	
If so, what was the substance (e.g. chemical/medication), and what was the resulting health problem?	
3. Have you been exposed to any of the following?	
Asbestos	
If so, are you on the Asbestos Exposure Register?	
Construction/industrial dust (e.g. coal, silica)	
Heavy metals (e.g. cadmium, lead, mercury)	
Cytotoxics, glutaraldehyde, isocyanates, solvents or resins	
4. Have you ever required assessment and/or treatment for any work-related exposure or illness?	
If you answered yes to any of the above questions in Section K , please provide further details:	
Section L – Noise	
1. Have you been exposed to excessive loud noise in the past without wearing protection, including hobbies?	
If yes, please specify:	
2. Have you ever had a hearing test done?	
If yes, was the result in the normal range and when was it done?	

3. Do you have any hearing problems which affects or may affect your ability to perform the job you have applied for?		
If yes, please specify:		
Section M – Vision		
1. Do you have any visual impairment which affects or may affect your ability to perform the job you have applied for?		
If yes, please specify:		
2. Do you have colour-blindness?		
Section N – Tuberculosis		
Country of Birth:		
Please list countries you have travelled to and/or lived in for 3 months or more in the past 5 years:		
Have you worked in a healthcare setting outside of New Zealand in the last 3 years?		
If yes, please specify:		
Country	Length of Time Worked	
Have you ever been diagnosed with or treated for TB?		
Have you ever had contact with TB without respiratory protection?		
Have you worked in an area where you may have been exposed to TB i.e. bronchoscopy, laboratory, microbiology or mortuary?		
Have you had a recent chest x-ray related to TB screening or exposure?		
Do you currently have any of the following symptoms:		
	Persistent cough	
	Coughing up blood	
	Night sweats	
	Extreme lethargy	
	Sudden unexplained weight loss	
If yes, please provide further details:		

Section O – Vaccination History

Working with patients and infectious material puts you at risk of contracting and transmitting vaccine- preventable diseases. It is important that you are aware of the risks and that Southern DHB has evidence of your immune status for the vaccine preventable diseases listed below.

If you are not immune, vaccination(s) appropriate for the position applied for will be offered.

Infectious Disease	Have you ever been vaccinated against this disease?	Vaccination record attached	Have you had your immunity checked?	Lab result attached
Hepatitis A				
Hepatitis B				
Varicella Zoster (Chickenpox)				
Mumps				
Measles				
Rubella				
Tuberculosis	Have you received a BCG vaccination?		Mantoux or Quantiferon-TB Gold, within 2 years	
Meningococcal				
	Please specify which vaccine/strain you received:			
Pertussis (Whooping Cough)				
Seasonal influenza				
Tetanus				

If you have previously had your immunity checked but are unable to provide evidence, do you consent to us accessing your electronic laboratory records?

ONLY COMPLETE THIS SECTION IF APPLYING FOR A CLINICAL POSITION

Section P – Biological

1. Do you have any infectious disease (e.g. a blood-borne virus such as Hepatitis B, Hepatitis C, Human Immunodeficiency Virus) that could be transmitted to others in the course of your employment and/or transmitted to patients under your care?

If yes, please specify:

2. Have you previously been infected with Multi Resistant Staphylococcus Aureus (MRSA)?

If yes, please specify:

DECLARATION

I declare that the above information is true and accurate to the best of my knowledge. I understand that deliberate intent to mislead and/or supply false information to the questions contained in the questionnaire may compromise my employment with Southern DHB.

Signed:

Date:

Please check all applicable fields have been completed and are displaying correctly then email this form to

OccupationalHealthOtago@southerndhb.govt.nz

We recommend saving this form by clicking **File > Print** then selecting **Microsoft Print to PDF** as your printer