Confidential Occupational Health Check

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

FOR EXPOSURE PRONE PROCEDURES / EXTERNAL TO HEALTH BOARD EMPLOYEE POSTS WHICH ROLE INVOLVE CONTACT OR ACCESS TO PATIENTS / INTERNAL TO HEALTH BOARD AND ROLE HAS CHANGED TO INVOLVE CONTACT OR ACCESS TO PATIENTS

[PLEASE NAVIGATE THE FORM ELECTRONICALLY USING THE TAB BUTTON – or complete using black ink]

PART A – To be completed by Hiring Manager	
Appointment to the post of: GP Team Leader Band/Grade: TBA Expected Start Date: 1/10/21 ☒ Full time / ☐ part time /sessions ☒Permanent / ☐ Temporary / ☐ Honorary **Job Ref:**	Department/Ward: Base/Location: Brynmawr Surgery Directorate/Division/Manager: Andy Williams Manager Contact No: 07392 050426 Managers Email Address: Andrew.williams22 @wales.nhs.uk E-mail clearance to: Recruitment.serviceSE@wales.nhs.uk
What are the specific requirements of the job? (tick the appropriate boxes) ☒**Role will involve contact / access to patients** ☒**Exposure prone procedures (EPP)** ***see note*** *1 of explanation notes*	
What are the specific requirements of the job which require health surveillance? ☐Display Screen Equipment user ☐ Noise (> than 80dBa TWA) ☐Night workers ☐Respiratory sensitisers, specify sensitising agent: _____ ☐Skin sensitisers, specify: latex or other sensitising agent: _____ ☐Hand Arm Vibration, specify vibration tool: _____ ☐ Other - specify agent and type of surveillance: ___	
PART B – To be completed by all employees. Please return completed **WITHIN 3 DAYS OF RECEIPT.** You should return your questionnaire directly to Occupational Health. **The contents of this form are held in strict confidence by Occupational Health.** Before completing you should read the declaration to be signed in Part I and the information already completed in Part A above.	
Title: Ms ☐ Miss ☐ Mrs☒ Mr☐ Mx☐ Dr☐ Professor ☐	Male: ☐ Female: ☐ Non Binary/Third Gender ☐ Prefer not to say ☐ Prefer to use my own term ☐

Surname/Family name:		First name:
Previous names (if applicable):		Date of birth:
NI No:		Proposed Job Title:
Department:	Site:	Are you new to working for the NHS? Yes ☐ No ☐
Home Address:		
Post code:	E mail:	
Mobile:		Tel home:
Name of GP:		Tel No of GP:
Address of GP:		

Are you currently or have you ever been employed by this organisation Yes ☐ No ☐

If yes please confirm dates: From: to: (*please use dd/mm/yyyy format)*

Previous Employment in the Past 5 Years			
Employer	**Job Title**	**Start date**	**Finish date**

PART C CURRENT HEALTH STATUS- To be completed by all applicants (please tick boxes as applicable)

Please read the following two statements carefully. Please tick the statement which applies to you.

A	I am **not aware** that I have a health condition or disability that might impair my ability to undertake effectively the duties of the position that I have been offered.	☐
B	I **do** have a health condition or disability that might affect my work and may require special adjustments to my work or my place of work.	☐

COVID-19 Assessment

1.	In relation to Coronavirus (COVID 19), have you previously been advised to shield, or do you fit the criteria for people who are at increased risk of severe illness from Coronavirus (COVID19)? *See Note 1 for further information.*	**YES** ☐ **NO** ☐
	If **YES**, Please provide further details:	

Allergies

2.	Do you have any known allergies?	**YES** ☐ **NO** ☐	If **YES**, Please provide further details:	

Tuberculosis (TB) Assessment- *See Note 2*

3.	Do you have any of the following?	A cough which has lasted for more than 3 weeks?	**YES** ☐ **NO** ☐
		Unexplained Weight Loss?	**YES** ☐ **NO** ☐
		Unexplained fever?	**YES** ☐ **NO** ☐
4.	Have you lived or spent time for 3 months or more outside the UK in the last 5 years?		**YES** ☐ **NO** ☐
	If YES, Please list the countries that you have lived in:		
5.	Have you worked in a high-risk TB clinical setting for 4 weeks or longer? i.e. worked on designated TB wards / TB clinics or worked in prisons, with the homeless or asylum seekers		**YES** ☐ **NO** ☐
6.	Have you had TB or been in contact with recent contact with open TB?		**YES** ☐ **NO** ☐
	If YES, Please provide further details of subsequent screening/treatment:		
7.	Have you had a BCG Vaccination in relation to TB?		**YES** ☐ **NO** ☐

8.	Do you have a BCG Scar?	**YES** ☐ **NO** ☐	YES, Please state site of scar:	
9.	Have you ever had a TB Test e.g. Heaf/Mantoux/Quantiferon	**YES** ☐ **NO** ☐	If YES, Please state result:	

PART D IMMUNISATION STATUS *see note 3*		YES	NO	YEAR	RESULT
Hepatitis B vaccination	1st dose	☐	☐		
	2nd dose	☐	☐		
	3rd dose	☐	☐		
	Booster	☐	☐		
Hepatitis B surface antibody blood test (*please enclose copy if available) EPP posts must supply a copy*		☐	☐		
Hepatitis B surface antigen blood test (*please enclose copy if available) EPP posts must supply a copy*		☐	☐		
Hepatitis C antibody blood test (*please enclose copy if available) New EPP posts since 2002 must supply a copy*		☐	☐		
HIV blood test *(please enclose copy if available) New EPP posts since 2008 must supply a copy*		☐	☐		
Measles, mumps, rubella (MMR) vaccination *(please supply documentary evidence)*	1st dose	☐	☐		
	2nd dose	☐	☐		
Measles blood test *(please enclose copy if available)*		☐	☐		
Mumps blood test *(please enclose copy if available)*		☐	☐		
Rubella (German measles) blood test *(please enclose copy if available)*		☐	☐		
Tetanus , diphtheria, polio vaccination		☐	☐		
Have you had a diphtheria / tetanus / polio & pertussis (whooping cough) vaccine in the last 5yrs?		☐	☐		
Meningitis C vaccination		☐	☐		
Have you had chickenpox?		☐	☐		
Where you born or raised outside the UK?		☐	☐		
Varicella (chickenpox) blood test		☐	☐		
Varicella (chickenpox)vaccination *(please supply documentary evidence)*	1st dose	☐	☐		
	2nd dose	☐	☐		
Hepatitis A vaccination		☐	☐		
Typhoid vaccination		☐	☐		
COVID-19 Vaccination	1st dose	☐	☐		
	2nd dose	☐	☐		
Is this your first EPP post in the NHS? *(EPP staff only – see note 4).* If no please provide name of organisation/hospital that undertook your screening:		☐	☐		
Is this your first post in the NHS?		☐	☐		
Do you wish to be offered an appointment for Blood Borne Virus Screening (Hep B SAg, Hep C AB and HIV?) *(See note 5)*		☐	☐		
Have you ever received any other vaccinations? If yes please attach details:		☐	☐		

PART E LATEX QUESTIONNAIRE

To be completed by all staff who may come into contact with Latex during the course of employment

	YES	NO
Do you believe you have an allergy to latex? If yes, what type of allergic reaction: What latex product(s) caused it:	☐	☐
Have you suffered from redness, irritation, or swelling at the site of exposure to latex e.g. gloves, balloons, condoms? If yes, how soon after latex exposure do the symptoms begin:	☐	☐
Have you ever noticed any local swelling following medical or dental treatment? If yes, how soon after do the symptoms begin:	☐	☐
Are you allergic to any of the following foods: bananas, avocados, raw potatoes, kiwi fruit or chestnuts? If yes, to what:	☐	☐
Do you have any other nut or food allergies? If yes, what:	☐	☐
Have you ever suffered from a very severe allergic reaction (anaphylaxis)? If yes, what was the cause:	☐	☐
Have you suffered from: a) Asthma	☐	☐
b) Eczema e.g. childhood or infancy	☐	☐
c) Dermatitis of hands (redness, soreness, cracking)	☐	☐
When exposed to latex either at work or at home or as a patient have you ever had: a) Itchy /watery eyes	☐	☐
b) Sneezing / rhinitis / runny nose	☐	☐
c) Wheezing / tight chest	☐	☐
d) Rashes other than at the site of latex exposure e.g. urticaria (nettle rash)	☐	☐
e) Collapse (anaphylaxis)	☐	☐
In your lifetime have you had four or more operations?	☐	☐
Does your current work involve frequent glove use?	☐	☐
If yes, on average how many hours each day are gloves worn? (state hours)	Hours:	
On average, how many times a day do you change latex gloves? (state times)	Times:	
ADDITIONAL COMMENTS:		

PART F – NIGHT TIME WORKERS - Please complete if your job involves night-time work i.e. regularly working at least 3 hours between 11pm and 6am.		
Do you have or have you ever had:	**YES**	**NO**
Diabetes?	☐	☐
If **Yes** does this require treatment with insulin injections on a strict timetable?	☐	☐
A heart or circulatory disorder?	☐	☐
If **Yes** does this affect your physical stamina?	☐	☐
Epilepsy?	☒	☐
If **Yes** please indicate seizure frequency and whether they occur at night?	☐	☐
A digestive disorder or any condition where the timing of a meal is particularly important?	☐	☐
A chronic chest disorder where night-time symptoms are particularly troublesome?	☐	☐
Any other condition requiring regular medication on a strict timetable?	☐	☐
A mental health condition e.g. depression or anxiety?	☐	☐
Any other medical condition / health factors / disability, which may affect your ability to do night-work?	☐	☐
If you have answered 'yes' to any of the above, please provide further details below:		

PART G- FOOD HANDLERS QUESTIONNAIRE - Please complete if your role will involve handling food		
At present, or in the last 14 days, are you suffering from:	**YES**	**NO**
Diarrhoea and/or vomiting?	☐	☐
Stomach pain, nausea or fever?	☐	☐
Skin infections of the hands, arms or face e.g. boils, styes, septic finger, discharge from eye/ear/gums/mouth? If yes please provide details? _____	☐	☐
Jaundice?	☐	☐
Do you have or experience:	☐	☐
a) A recurring bowel disorder?	☐	☐
b) Recurring infections of the skin, ear or throat?	☐	☐
Have you ever had typhoid or paratyphoid fever or are you now known to be a carrier of *Salmonella* Typhi or Paratyphi?	☐	☐
Are you a carrier of any type of *Salmonella*?	☐	☐
In the last 21 days have you had contact with anyone, at home or abroad, who may have been suffering from typhoid or paratyphoid?	☐	☒
Countries visited in the last 6 weeks:		

PART I - DECLARATION

I declare that the information I have given on this form is true to the best of my knowledge and belief. I understand that if any information is false or has been deliberately omitted, I may be regarded as ineligible for employment or liable to be dismissed. In such cases where an opinion on any adjustment is required I will be contacted to discuss my abilities and the recommended adjustments. I understand that Occupational Health may with my permission:

- Obtain immunisation and screening results from any previous Occupational Health Department or other NHS organisation.

- Transfer my immunisation and screening results to other NHS organisations where I am working, where I intend to work, be on placement or part of a rotational training post.

Please tick the box if you consent to the above ☐ ***see note 6***

I understand that medical details will not be divulged without my permission to any person outside the Occupational Health Service but that an opinion about my fitness to work, including information about my clearance to undertake clinical work and immunisations, will be given to management.

Print Full Name: _____

Signature:_____ Date: _____

PLEASE NOTE: WRITTEN SIGNATURE ONLY (typing your name will not be accepted)

(Once signed please send completed form directly to Occupational Health - *see note 7*)

EXPLANATION NOTES

Note 1: COVID-19 Assessment- People who are defined as clinically extremely vulnerable are at very high risk of severe illness from coronavirus. There are 2 ways you may be identified as clinically extremely vulnerable:

1. You have one or more of conditions listed below, or
2. Your clinician or GP has added you to the Shielded Patient List because, based on their clinical judgement, they deem to you be at higher risk of serious illness if you catch the virus.

People with the following conditions are automatically deemed clinically extremely vulnerable:

- solid organ transplant recipients
- people with specific cancers:
    - people with cancer who are undergoing active chemotherapy
    - people with lung cancer who are undergoing radical radiotherapy
    - people with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
    - people having immunotherapy or other continuing antibody treatments for cancer
    - people having other targeted cancer treatments that can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
    - people who have had bone marrow or stem cell transplants in the last 6 months or who are still taking immunosuppression drugs
- people with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary disease (COPD)
- people with rare diseases that significantly increase the risk of infections (such as severe combined immunodeficiency (SCID), homozygous sickle cell disease)
- people on immunosuppression therapies sufficient to significantly increase risk of infection
- problems with your spleen, for example splenectomy (having your spleen removed)
- adults with Down's syndrome
- adults on dialysis or with chronic kidney disease (stage 5)
- women who are pregnant with significant heart disease, congenital or acquired
- other people who have also been classed as clinically extremely vulnerable, based on clinical judgement and an assessment of their needs. GPs and hospital clinicians have been provided with guidance to support these decisions

Note 2: TB status –New staff entering the UK from high-risk countries (TB incidence rate > 40 in 100,000) should provide evidence of their TB status. This could include details of vaccination, skin test, blood tests and chest X-ray. Chest X rays will need to be repeated prior to clearance being issued, unless evidence is available from a UK accredited source. New healthcare workers who have worked in high-risk TB clinical setting for 4 weeks or longer i.e. worked on designated TB wards / TB clinics or worked in prisons, with the homeless or asylum seekers to have an interferon test.

If you develop the following symptoms (compatible with TB): cough lasting longer than 3 weeks, fever, night sweats, weight loss, loss of energy, coughing up blood seek a medical opinion from your GP and contact Occupational Health.

Note 3: Immunisation Status-All Healthcare workers/staff with patient contact are required to provide information relating to their immunity to TB, measles, mumps, rubella (MMR), chickenpox, and hepatitis B.

If you come into contact or become symptomatic of a communicable infection contact Occupational Health for advice, or if out of hours, seek a medical opinion from your GP.

Posts are offered on the understanding that the applicant will comply with local requirements regarding immunisation and screening, and sharps and body fluid contact management.

Immunocompromised staff: If you are immunocompromised (e.g. by steroids, HIV, medical treatment etc)

it may be unsafe for you to:

- Have live vaccines
- Work in certain areas
- Perform some surgical/invasive procedures

If you become immuno-compromised during your employment, please notify Occupational Health in confidence.

Measles, mumps and rubella (MMR): The Joint Committee on Vaccination and Immunisation (JCVI) advises that the MMR vaccine is especially important in the context of the ability of staff to transmit measles, mumps or rubella infections to vulnerable groups. While healthcare workers may need MMR vaccination for their own benefit, they should also be immune to measles and rubella in order to assist in protecting patients. Satisfactory evidence of protection would include **documentation of having received two doses of MMR or having had positive antibody tests for measles and rubella.**

Varicella (chickenpox): Varicella vaccine is recommended for susceptible staff who have regular clinical contact with patients, are directly involved in patient care or who have social contact with patients but are not directly involved in patient care (e.g. receptionists, catering staff, ward clerks, porters and cleaners). For laboratory staff vaccination should be offered to susceptible (i.e. seronegative) individuals who may be exposed to varicella virus in the course of their work in virology laboratories.

Those with a definite history of chickenpox or herpes zoster can be considered protected. Healthcare workers with a negative or uncertain history of chickenpox or herpes zoster should be serologically tested and vaccine only offered to those without the varicella zoster antibody. Satisfactory evidence of protection would include a history of chickenpox/herpes zoster **or documentation of having received two doses of varicella vaccine or having had positive antibody test.**

MacMahon *et al*. 2004 showed that a history of chickenpox is a less reliable predictor of immunity in individuals born and raised in tropical or subtropical climates and routine testing should be considered regardless of a positive history of past infection.

Note 4: **Exposure Prone Procedures (EPP) –** are those procedures where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissue (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.

Occupations undertaking EPPs include surgeons (including FP1 & FP2 doctors with rotation into one of the EPP areas), dental staff, theatre staff, midwives, paramedics, podiatrists performing surgical techniques, A&E doctors and nurses. This list is not exhaustive as EPP clearance is based on risk assessment.

EPP staff must provide documentary evidence of hepatitis B status. Documentary evidence of hepatitis C and HIV status is also required for staff undertaking EPPs for the first time. This complies with Department of Health Clearance Guidelines for those new to any EPP post commencing after January 2008.

The evidence must be from an identified validated sample (IVS). These samples are those taken by an Occupational Health department where an individuals' identity is checked by photographic ID. This includes a passport, photographic driving licence or a photographic ID card.

Health clearance for EPP work cannot be given until these results have been received and processed. If you have previous blood results and/or documented evidence of relevant vaccinations please supply a copy when you submit this form.

If results are not available you will be tested in Occupational Health and health clearance for EPP work will be delayed until the results are processed.

If you undertake EPP work and you suspect or know that you are a carrier of HIV, hepatitis B or hepatitis C you have a legal duty to inform Occupational Health. This also applies if you suspect that you may have been exposed to a blood borne virus.

Note 5: BBV Screening- All HCWs who are new to the NHS should be offered a pre-test discussion and a Hepatitis C antibody test, HIV test and Hepatitis B (BBV Screening). Declining a test for Hepatitis B, Hepatitis C or HIV will not affect the employment or training of HCW's who will not perform EPPs. If you wish to be invited for an appointment to discuss and be offered BBV Screening, please indicate on the form.

Note 6: Consent to Access Health Information

Occupational Health may need to contact your previous Occupational Health department for immunisation and screening records. Your written consent is required prior to being able to do this.

Requests for reports from other Occupational Health departments or information from other medical practitioners, who are responsible for your clinical care, are subject to the Access to Medical Reports Act 1988. Your rights under the act must be explained and respected as part of the process of obtaining informed consent. In summary these include:

- The right to see the report before it is sent.
- The right to ask the doctor to amend or modify information considered inaccurate.
- 21 days from notification the right to seek access to the report.

Please note that the information which you give will be used for the following purposes: to enable the organisation to create a record of your application; to enable the application to be processed; to enable the organisation to compile statistics, or to assist other organisations to do so, provided that no statistical information that would identify you as an individual will be published. The information will be kept securely, and will be kept no longer than necessary.

Note 7: Please return completed **WITHIN 3 DAYS OF RECEIPT** to the appropriate Occupational Health Department as detailed below:

By post to:

ST WOOLOS HOSPITAL	**NEVILL HALL HOSPITAL**	**YSBYTY YSTRAD FAWR**
STOW HILL	**BRECON ROAD**	**YSTRAD FAWR WAY**
NEWPORT	**ABERGAVENNY**	**YSTRAD MYNACH**
NP20 4SZ	**NP7 7EG**	**CF82 7GP**
TEL: 01633 238349	**TEL: 01873 732849**	**TEL: 01443 802442**

By email to: occhealth.admin.ABB@wales.nhs.uk

The Occupational Health Department can be contacted on the above details

Please DO NOT return this form to the Recruitment Department