REF NO:


# NURSE ON CALL

**Nursing Services and Recruitment**

59 Ranelagh, Dublin 6, Ireland.
Tel: (3531) 496 5199, Fax: (3531) 496 5690 / (3531) 406 2079
Internet: http://www.nurseoncall.ie E-mail: nurseoncall@ireland.com

50 Patrick's Street, Cork, Ireland
Tel: (353) 21 422 2830 Fax: (353) 21 427 9939
Internet: http://www.nurseoncall.ie Email: nurseoncallcork@ireland.com


## INFORMATION ON THE MEDICAL REQUIREMENTS

There are 2 forms needed to complete your medical requirements.

**1. Occupational Health Checklist** – this form should only be filled out and signed by the *applicant* when all the medical tests/results are completed.

**2. Confidential Health Declaration** – *pages 1 to 3* must be filled out and signed by the *applicant* while *page 4* must be completed, signed and stamped by the *GP or OHP*.

Things to remember about these forms:

1. Fill out both forms completely and legibly. You should bring this home and submit/post to us along with all the required medical test results.

2. Make sure that your GP/OHP fills out *page no. 4* completely and that his/her signature and hospital/clinic official stamp are on it. This form is unacceptable and will be returned if it is incomplete and without the GP's/OHP's signature and stamp.

3. All medical tests stated on Occupational Health checklist should be strictly followed. Please note that not only Hepatitis B antibody level is required but the complete Hepatitis B profile. Also blood tests for Measles, Mumps, Rubella and Varicella should now have Igg and Igm results separately.

4. Forms should be completed as specified above to avoid delays in completing/updating your file.

Should you have further query about this please do not hesitate to contact the Nurse Interviewer on the numbers below anytime between 9am and 6pm:

*Dublin Office – 01 4965199*

*Cork Office – 021 4222830*

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## OCCUPATIONAL HEALTH CHECKLIST

**Candidate Name:** _____

I, _____, *candidate's name* confirm that I will complete all the following HSE medical/occupational requirements before I commence any agency shifts.

**For All Posts**
A Completed Confidential Health Declaration to include the following:

- BCG Records (if available in country of origin) ☐
- Recent Heaf/Mantoux Test ☐
- HBSag (surface antigen level) ☐
- Hepatitis B Core antibody (Anti-Hep B c) ☐
- Hepatitis B Surface Antibody ☐
- Hepatitis C Antibody ☐
- Immunisation records to include Diptheria, Tetanus & Polio ☐
- Measles IgG and IgM ☐
- Mumps IgG and IgM ☐
- Rubella IgG and IgM ☐
- Varicella IgG and IgM ☐

I have been made aware of the Occupational Health Policies pertaining to the Irish Healthcare setting.

**Signed:** _____ **Candidate Signature**
**Date:**

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# OCCUPATIONAL HEALTH SERVICE

## CONFIDENTIAL HEALTH DECLARATION

Pre-placement assessment aims to ensure so far as is possible that you are fit for the post for which you have applied. The contents of this form will remain confidential to the Occupational Health Service and will not be revealed to anyone else without your written consent.

This questionnaire forms part of the appointments procedure and failure to declare a health problem or giving false information can result in the termination of your employment. A disability or health problem does not preclude consideration for the job and applications from suitable people with disabilities are welcome

| | |
|---|---|
| **Post Applied For:**<br>**Location:**<br>**Department:** | **Personnel Officer/ Line manager:**<br><br>**Proposed Start Date:** |

| | |
|---|---|
| **Personal details:**<br><br>**SURNAME:** | **Other NAME(S):** |
| **Date of Birth (dd/mm/yr):** | **Sex: Male/Female** |
| | **Previous name (if applicable):** |
| **Address:** | |
| | **Telephone No:** |

| | |
|---|---|
| **General Practitioner:** | |
| **Address:** | |
| | **Telephone No:** |

**PREVIOUS OCCUPATIONS - starting with present post**

| JOB TITLE | EMPLOYER | FROM | TO |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**PREVIOUS SICKNESS ABSENCE (time lost from work or school due to illness over last 2 years)**

| LENGTH OF ABSENCE | REASON FOR ABSENCE |
|---|---|
| | |
| | |
| | |
| | |

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PLEASE ANSWER **YES** OR **NO** AND **IF YES**, PLEASE GIVE DETAILS IN THE SPACE PROVIDED.

| | | NO | YES | DETAILS |
|---|---|---|---|---|
| 1 | Are you in good health at present? | | | |
| 2 | Have you ever been treated in hospital ? | | | |
| 3 | Have you ever suffered a work related illness or accident, or given up work because of ill health? | | | |
| 4 | Do you smoke cigars/cigarettes/pipe/other? | | | If YES, how many per week? |
| 5 | Do you drink alcohol? | | | If YES, how much per week? Units |
| 6 | Are you having treatment of any kind at the moment? | | | |
| 7 | Are you waiting for any treatment or investigation? | | | |
| 8 | Have you been seen or examined by a doctor in the last 6 months? | | | |
| 9 | Do you have any problem with your vision or your eyes? | | | |
| 10 | Do you have any problems with your hearing or your ears?. | | | |
| 11 | Do you have any physical limitation which may affect your ability to work? | | | |
| 12 | Have you ever had any kind of back problem leading to time off work? | | | |
| 13 | Have you ever had any kind of problems with your joints, including pain, swelling or restricted movements? | | | |
| 14 | Do you have any difficulty in standing, bending, lifting or other movements? | | | |
| 15 | Have you ever had any kind of skin problem? | | | |
| 16 | Have you ever had diabetes, thyroid or gland problem? | | | |
| 17 | Have you ever had seizures, blackouts or epilepsy? | | | |
| 18 | Have you ever had asthma, bronchitis or chest problems? | | | |
| 19 | Have you ever had Tuberculosis (TB)? | | | |
| 20 | Have you had a cough for more than 3 weeks in the last 12 months? | | | |
| 21 | Have you ever coughed up blood? | | | |
| 22 | Have you had any unexplained loss of weight or fever in the last 12 months? | | | |
| 23 | Has any member of your family suffered from TB? | | | |
| 24 | Have you ever had any mental illness? | | | |
| 25 | Have you ever sought help for mental, psychological or emotional problems? | | | |
| 26 | Have you ever had a drug or alcohol problem? | | | |
| 27 | Do you have any allergies? | | | |
| 28 | Have you ever had hepatitis or jaundice? | | | |

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| | | | | |
|---|---|---|---|---|
| 29 | Have you ever received treatment for a gastric or bowel problem? | | | |
| 30 | Have you ever had heart circulation or blood pressure problems? | | | |
| 31 | Do you have any other medical condition? | | | |
| 32 | Disorder of the bladder or kidneys | | | |
| 32 | Have you ever been exposed to any of the following substances at work?:<br>GLUTARALDEHYDE _____ FORMALDEHYDE _____ CYTOTOXIC AGENTS _____<br>PAINTS/SOLVENTS _____ ASBESTOS _____ NON-IONISING RADIATION _____<br>OTHER _____ | | | |
| 33 | What is your height? | What is your weight? | | |
| 34 | Please list any sports/hobbies | | | |
| 35 | Do you have a BCG scar? (normally on the left upper arm) | | | |
| 36 | Have you ever had chickenpox? | | | |

**DECLARATION**

*I declare that all of the above statements and information are true to the best of my knowledge and I understand that making a false declaration could lead to disciplinary action including the termination of my employment.*

SIGNATURE: _____ DATE: _____

PRINT SIGNATURE: _____

**IMMUNISATION HISTORY;**
**In order to protect you in your employment with the HSE, we routinely carry out a full immunisation review as part of pre-placement screening. To speed up the process and to ensure you have the required immunisations needed for your job, we ask that you complete the immunisation history where possible.**
**In most cases your General Practitioner, previous occupational health service or community care department will have a record of your vaccination history.**

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# IMMUNISATION/INVESTIGATION HISTORY

Please provide information regarding previous immunisations/investigations on the form below to the Occupational Health Service of the HSE.
Have you ever had any of the following immunisations or tests? - Please indicate YES or NO and give dates and test results where known.

| IMMUNISATION | NO | YES | DATE | TEST RESULT |
|---|---|---|---|---|
| TETANUS | | | | |
| POLIOMYELITIS | | | | |
| RUBELLA (German Measles) | | | | |
| TB Test (Heaf, Tine, Mantoux) | | | | |
| BCG (TB immunisation) | | | | |
| DIPHTHERIA | | | | |
| TYPHOID | | | | |
| MENINGITIS A & C | | | | |
| HEPATITIS A | | | | |
| MEASLES | | | | |
| IVS HEPATITIS C | | | | |
| HEPATITIS B:*see below | | | | |
| Injection No 1 | | | | |
| Injection No 2 | | | | |
| Injection No 3 | | | | |
| Titre Level | | | | iu/l |
| Booster Dose | | | | |
| Titre following Booster | | | | iu/l |
| VARICELLA Zoster | | | | |
| MUMPS | | | | |

**Exposure Prone Staff Categories** include Doctors and Nurses applying for posts which would require them to work in Theatres, Accident and Emergency, Anaesthetics, ENT, Radiodiagnosis, Obstetrics & Gynaecology, Dentists & Paramedics.
* Information about Hepatitis B Status is essential for all Exposure prone posts (EPP). Please ensure that you supply copies of titre results and that your GP or Occupational Health Service signs and stamps the form below.

**I confirm that the information supplied above is correct to the best of my knowledge.**

SIGNATURE: _____ DATE: _____

DESIGNATION: GP/ OHP/ OHN. _____

**OFFICIAL STAMP of GP or OHS**

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