Health Questionnaire

Employee Information			
First Name:		Surname:	
Job Title at NCBS:		Department:	

Work Health History		Please give details of the cause of these absence(s)
How many days off work due to illness or injury have you had in the past 2 years?	_____ Days	

Health History		If YES, give details and dates:
Have you had any major illness/operations/accidents during the past five years?	YES ☐ NO ☐	
Do you suffer from any recurring health or physical problems?	YES ☐ NO ☐	
Do you suffer from any allergies or recurring conditions that our First Aiders should be notified of?	YES ☐ NO ☐	
Are you currently receiving any medical treatment?	YES ☐ NO ☐	

The Equality Act 2010 describes disability as: *"A physical or mental impairment which may have a substantial or long term adverse effect on the person's ability to carry out normal day to day activities."*

Disability		If YES, give details:
Bearing in mind the above definition, do you consider yourself to have a disability?	YES ☐ NO ☐	
If yes, do you foresee that your disability could impact on your ability to carry out the duties as described at interview?	YES ☐ NO ☐	
Do you require any special provisions/adaptations in order to carry out the duties described to you at interview?	YES ☐ NO ☐	

Other health considerations:		If YES, give details:
Are there any other health or physical considerations which the Society should be aware of? Please include conditions such as back problems which you may not consider to be a disability but may require changes to your workstation.	YES ☐ NO ☐	
If you use an Epipen, are you happy for one of our First Aiders to administer if necessary?	YES ☐ NO ☐	

Declaration:
1. I declare that all the statements and information in this form is and remains true and complete, to the best of my knowledge and belief. I understand that if the information I have provided in this questionnaire contains any material gaps, or omissions, my employment may be terminated or benefits might not be payable. 2. I understand and consent to the seeking of further medical information from my GP/specialist if considered necessary under the Access to Medical Reports Act 1988. 3. I understand and accept that I may be required to attend a medical examination, carried out by a doctor nominated by the Society. 4. I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998 to process my personal information with respect to the answers I have given in this form
Signature: Date: