

HEALTH DECLARATION: RECRUITMENT (JERSEY RESIDENT APPLICATION)

We want to be sure that we can reasonably expect you to be able to give regular and effective service, so we need you to provide us with some details about your health record. Each declaration we receive is considered individually and no decision to reject you on medical grounds will be made without referral to our Occupational Health Adviser. The States of Jersey is an equal opportunities employer and recruits on the basis of ability, not perceived disability. Any information given on disabilities or medical history will help us in assessing where reasonable adjustments to duties or the workplace can be made.

PLEASE USE BLOCK CAPITAL LETTERS ON ALL SECTIONS OF THIS FORM

Post applied for: (please circle) FT / PT / CASUAL / BANK Full job title

Contracted hours: PERMANENT / TEMPORARY SHIFT WORK / INCLUDES NIGHTS

Department/Location: Code:

Contact in Department: Tel. No.:
(please print) Please enclose an up to date job description

PLEASE COMPLETE **ALL** QUESTIONS. WHERE YOU HAVE INDICATED YES TO ANY QUESTION YOU MUST PROVIDE **FULL** DETAILS INCLUDING DATES, TREATMENTS, MEDICATION AND OUTCOME.

Full Name: Maiden name: Title:

Male Female

Address:
.....
.....

Contact Number: Home: Mobile:

Date of Birth: / / Height: Weight:

1a Do you have any condition which might affect your ability to work or attend work? Yes No
(If yes, please give details)

1b If your answer to **1a** was "Yes", please indicate what facilities, adjustments or equipment (if any) would enable you to perform your duties most effectively? (Please use a separate sheet if necessary)

2 Have you ever:

- taken any form of regular medicine to control or stabilise a condition Yes No
(e.g. insulin for diabetes or ventolin for asthma)
- undergone any operation or hospital treatment or had any serious accident? Yes No
(if yes please give details including dates) (please use a separate sheet if necessary)

3a Have you ever had any disease or been diagnosed as having an infectious disease other than normal childhood illnesses, colds and flus? (e.g. Hepatitis A, B, C. Tuberculosis, Malaria) Yes No

3b Do you have a visible TB scar? Yes No

4a Have you ever left, or been denied, any employment on the grounds of:
● ill-health? Yes No

● unsatisfactory attendance? Yes No

4b Have you ever been retired on the grounds of ill-health? Yes No

4c Have you ever received any warning regarding your sickness record from any current/previous employer? Yes No

*If you have answered **yes** to any of the above, please give details and dates*

5a How many days have you taken off work for reasons of sickness (both medically and self-certificated) in the last two years of your current/most recent employment?

Current 12 months

Previous year

days self-certificated

days medically certificated

(You must provide dates and full reasons for each separate absence)

5b If you have had more than 20 days sickness absence in the previous five years (not mentioned above), please provide dates and reasons

6 Have you ever had any drug or alcohol-related problem? Yes No

7 Do you have any known allergies? Yes No

MEDICAL IN CONFIDENCE (WHEN COMPLETED)

8 Have you ever had any:

- back, muscle or joint problems (e.g. slipped disc, rheumatism, arthritis)? Yes No
- work-related upper limb disorder or RSI (e.g. from keyboard/VDU)? Yes No

Do you have any ongoing symptoms from this condition? Yes No

9 Have you ever had depression, any stress related illness, eating disorder or other mental health impairment? Yes No

10 Have you consulted a doctor regarding an illness or condition in the past which you have not mentioned elsewhere on this form? Yes No

11 Please name all regular current prescribed medication including dosage:

12 May our medical adviser approach your General Practitioner for medical information on your health? *(Please complete the consent page on the back of this form)* Yes No

HEALTH DECLARATION

Please read this statement carefully before signing

I understand that I may be required to attend for consultation and physical examination if so requested by the Occupational Health Service. Failure to complete **full** details may result in my medical clearance being delayed.

I understand that this form will be retained by the Occupational Health Service. Further medical information may be requested from my doctor if considered necessary, and subject to my consent.

I understand that the medical evidence obtained will be used to supply an opinion as to my fitness to be employed in the stated job, together with recommendations regarding any adjustments which would be required on health grounds but that only broad terms will be used in any report, with the medical detail remaining confidential.

I declare that the information given on this form is, to the best of my knowledge, correct and complete. I understand that if, at any time in the future, the information is found to be false or incomplete, any contract of employment I have with the States of Jersey may be terminated by the States of Jersey without notice.

Name:

Signature: **Date:**

NB: *If any of the answers provided on this form change during any stage of the selection process you must notify us immediately.*

MEDICAL CONSENT FORM

Please complete the following sections and read through the declaration before signing below.

Please re-insert your full name and address and telephone number.

Name: Title:

Address:

.....

.....

Contact Number:

What is the full name, address and telephone number of your General Practitioner?

Name:

Address:

.....

.....

Contact Number:

If you have any concerns regarding this report, please discuss this confidentially with the Occupational Health Department by contacting us on 01534 510800

DECLARATION

By signing below I agree to my General Practitioner giving information about my medical condition to Capita Health Solutions.

I understand that this information is in medical confidence and that any advice given to the management about my health relating to my work will be in general terms only.

Please sign here	Date
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Please return to:



Capita Health Solutions
Axminster House
Devonshire Place
St Helier
Jersey
JE2 3RD