TLC Homecare & Healthcare Ltd.
TLC House
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Dooradoyle
Limerick

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Confidential Health Declaration

Pre-placement assessment aims to ensure so far as is possible that you are fit for the post(s) that are requested by our Clients. The contents of this form will remain confidential to TLC Homecare & Healthcare Ltd. and will not be divulged to anyone or any Client without your written consent.
This questionnaire forms part of the recruitment and placements procedure and failure to declare any health problems or giving false information will result in the termination of your employment with TLC Homecare & Healthcare Ltd.

Position Applied for: ______________________ **Proposed start date:** ______________________

Personal details:

Surname: ______________________ **Forename:** ______________________

Address: ______________________
____
____
____

D.O.B. ______________________

Sex: Male / Female

Previous Name: ______________________

Telephone No. ______________________

General Practitioner:

Name: ______________________ Address: ______________________
____
____
____

Telephone No. ______________________

Previous Sickness Absence (time lost from work due to illness over the last 2 years)

Length of Absence	Reason for absence

Please answer YES or NO. If YES, please provide details in the space provided

		YES	NO	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/pipe/cigarettes/other ?How many per week?			
5	Do you drink alcohol ? How many units per week ?			
6	Are you having any treatment of any kind at the moment ?			
7	Are you awaiting treatment or investigation?			
8	Have you seen or been examined by a doctor in the last 6 months ?			
9	Do you have any vision or eye problems ?			
10	Do you have any ear or hearing problems ?			
11	Do you have any physical limitation which may affect your work ability ?			
12	Have you ever had back problems leading to time off work ?			
13	Have you ever had joint problems, pain, swelling, restricted movement ?			
14	Do you have any difficulty standing, bending, lifting or other movement ?			
15	Have you had or do you have any kind of skin problem ?			
16	Have you had or do you have diabetes, thyroid or glandular problems ?			
17	Have you had or do you suffer from seizures, blackouts or epilepsy ?			
18	Have you or do you suffer from asthma, bronchitis or chest problems ?			
19	Have you ever had or do you suffer from Tuberculosis ?			
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 past year?			
23	Has any member of your family suffered from Tuberculosis ?			
24	Have you ever or are you currently suffering from a mental illness ?			
25	Have you ever sought help for mental, psychological or emotional			
	problems ?			
26	Have you ever had or do you have a current drug or alcohol problem ?			
27	Do you have any allergies ?			
28	Have you ever had or do you currently have hepatitis or jaundice ?			
29	Have you ever received treatment for gastric or bowel problems ?			
30	Have you ever had heart circulation or blood pressure problems ?			
31	Do you have any other medical condition ?			
32	Have you ever had bladder or kidney disorders ?			
33	Have you ever had chickenpox ?			
34	Do you have BCG scar ? (normally on the upper left arm)			

35 Have you ever been exposed to any of the following substances at work ?

Glutaraldehyde: ____________ Formaldehyde: ____________

Cytotoxic Agents: ____________ Paints/Solvents: ____________

Non-Ionising Radiation: ____________ Asbestos: ____________

36 What is your height ? ____________________

What is your weight ? ____________________

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 will lead to the termination of my employment.*

Name: ____________________

Signature: ____________________ Date: ____________

Immunisation/Investigation History

Please provide information regarding previous immunisations/investigatons on the form below to TLC Nursing Services.

Have you ever had any of the following immunisations or tests ? Please indicate YES or No and give dates of test results where known.

		YES	NO	Date	Test Result
1	Tetanus				
2	Poliomyelitis				
3	Rubella (German Measles)				
4	TB Test (Heaf,Tine,Mantoux)				
5	BCG (TB Immunisation)				
6	Diphtheria				
7	Typhoid				
8	Meningitis A & C				
9	Hepatitis A				
10	Measles				
11	Mumps				
12	Hepatitis C				
13	Hepatitis B (see below)				
14	Injection No. 1				
15	Injection No. 2				
16	Injection No. 3				
17	Titre Level				iu/l
18	Booster Dose				
19	Titre following Booster				iu/l
20	Varicella Zoster				

Exposure Prone Staff Categories include Nurses applying for positions which may require them to work in Theatres, A & E, Anaesthetics, ENT, Radio diagnosis, Obstetrics & Gynaecology,

Information about Hepatitis B is essential for **all** exposure prone positions. Please ensure that you supply copies of titre results and that your G.P. 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