

SUPPLY PRE-EMPLOYMENT MEDICAL QUESTIONNAIRE

PART 1 (Page 1): APPLICANT/JOB DETAIL

Please complete all sections as indicated for the Applicant or HR/Manager.

Please use Black ink when completing this form.

APPLICANT'S JOB DETAILS

To be completed by Manager/HR (Section A)	
Title Dr/Mr/Ms/Mrs/Miss/other:	
Surname:	Forenames:
Position applied for: SUPPLY TEACHER	How many hours per week will the employee work? Will the employee work nights? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
School:	
Department:	
Name of person Fitness for Work report to be sent to:	Pre-Employment Questionnaires (Supply) Education Personnel Management Ltd St Johns House Spitfire Close Ermine Business Park Huntingdon Cambridgeshire PE29 6EP

APPLICANT'S PERSONAL DEATAILS

To be completed by ALL applicants (Section B)		
Address:	Telephone numbers:	
	Home:	
	Work:	
Postcode:		
Date of Birth (dd/mm/yy) : / /	Age (Years):	Sex : M <input type="checkbox"/> F <input type="checkbox"/>
Personal Mobile Phone and Home Email information		
Do you consent to being contacted by email? If Yes, please provide your home email address	Yes <input type="checkbox"/> No <input type="checkbox"/>	Home email address:
Do you consent to being contacted on your mobile? If Yes, please provide your mobile phone number	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mobile phone number:

PART 1 (Page 2)

The table below is for completion by the prospective manager or HR. By ticking the relevant boxes in the leftmost column it will clarify to the Occupational Health department those elements of fitness of particular importance to the proposed employment. The Occupational Health department can then advise on any required health surveillance prior to employment.

KNOWN RISKS

To be completed by Manager/HR (Section C)

✓	Please tick in the first column if the work involves:-	
	Location/Hours	Work Environment Exposure to
<input type="checkbox"/>	Full Time	<input type="checkbox"/> Aggressive/challenging behaviour
<input type="checkbox"/>	Part Time	<input type="checkbox"/> Blood/body Fluids
<input type="checkbox"/>	Regular Night Work	<input type="checkbox"/> Chemicals
	Occupational Driving	<input type="checkbox"/> Contact with animals (incl. Bites, eg Weils Disease)
<input type="checkbox"/>	Light Service Vehicle	<input type="checkbox"/> Dust
<input type="checkbox"/>	PSV/Minibus/LGV/HGV	<input type="checkbox"/> Freezer temperatures
<input type="checkbox"/>	Ground Maintenance Equipment	<input type="checkbox"/> Fumes
<input type="checkbox"/>	Cat. D/or Equivalent	<input type="checkbox"/> Invertebrate venoms (insect bites/stings)
<input type="checkbox"/>	Car User	<input type="checkbox"/> Pets and diseases (eg, plants, animal husbandry)
<input type="checkbox"/>	Fork Lift Truck	<input type="checkbox"/> Plant Toxins
	Special Requirements	<input type="checkbox"/> Scabies
<input type="checkbox"/>	Work needing hearing protection	<input type="checkbox"/> Tetanus
<input type="checkbox"/>	Food Handler	<input type="checkbox"/> Noise
<input type="checkbox"/>	Colour Vision	<input type="checkbox"/> Traffic
<input type="checkbox"/>	Good long sight vision	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/>	Working alone (isolated)	<input type="checkbox"/> Vertebrate venoms (eg. Snake bites)
<input type="checkbox"/>	Working alone (but contact with others)	<input type="checkbox"/> Vibration/Vibrating Machinery
<input type="checkbox"/>	Working with children/students/vulnerable adults	<input type="checkbox"/> Weather/Outdoors (incl sun exposure)
<input type="checkbox"/>	Undertaking Exposure Prone procedures	<input type="checkbox"/> Working on uneven ground
	Physical Demands	<input type="checkbox"/> Sewage /Waste
<input type="checkbox"/>	Display Screen Equipment	<input type="checkbox"/> Asbestos
<input type="checkbox"/>	Physically Active	<input type="checkbox"/> There are no known risks associated to this role
<input type="checkbox"/>	Prolonged standing	
<input type="checkbox"/>	Regular Lifting	
<input type="checkbox"/>	Regular Bending	
<input type="checkbox"/>	Sedentary	
<input type="checkbox"/>	Working at heights	
<input type="checkbox"/>	Working in confined spaces	

PART 1 (Page 3) To be completed by All applicants (Section D)

Please answer all of the following questions by ticking the box		Yes	No
1	Are you on a hospital waiting list for investigation or treatment?	<input type="checkbox"/>	<input type="checkbox"/>
2	Are you regularly attending a hospital, community clinic or seeing a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
3	Have you ever left a previous employment through ill health or work related injury or condition	<input type="checkbox"/>	<input type="checkbox"/>
Are you suffering from or have you ever suffered from:		Yes	No
4	Any conditions relating to your heart or circulation ?	<input type="checkbox"/>	<input type="checkbox"/>
5	Any respiratory problems ? (e.g Asthma)	<input type="checkbox"/>	<input type="checkbox"/>
6	Any psychological problems ? (e.g nervous breakdown/depression)	<input type="checkbox"/>	<input type="checkbox"/>
7	Any eyesight condition that cannot be corrected by wearing spectacles or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
8	Any ongoing hearing problems or ear disorders? (e.g Tinnitus)	<input type="checkbox"/>	<input type="checkbox"/>
9	Any ongoing bone, muscle or joint problems? (e.g Recurrent back pain/Arthritis)	<input type="checkbox"/>	<input type="checkbox"/>
10	Any skin diseases or conditions that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
11	Any gastro-intestinal or abdominal problems? (e.g Hernia/Gall Stones)	<input type="checkbox"/>	<input type="checkbox"/>
12	Any blood or metabolic disorders? (e.g Anaemia/Diabetes)	<input type="checkbox"/>	<input type="checkbox"/>
13	Any neurological conditions? (e.g severe headaches/vertigo/epilepsy)	<input type="checkbox"/>	<input type="checkbox"/>
14	Any long term or debilitating illness? (e.g Multiple Sclerosis)	<input type="checkbox"/>	<input type="checkbox"/>

Vaccinations (please give dates of last vaccination)

Hepatitis A	/ /	Tuberculosis (BCG)	/ /
Hepatitis B	/ /	Tetanus	/ /
Initial injection	/ /	Polio	/ /
2 nd injection	/ /	Rubella (Measles)	/ /
3 rd injection	/ /		/ /
5 yr booster	/ /		/ /

PART 1 (Page 3) To be completed by All Applicants (Section E)

EQUALITY ACT 2010 It is unlawful to discriminate against disabled people in connection with employment. A person is considered disabled if they have a physical or mental impairment which has a substantial and long term adverse affect on their ability to carry out normal day-to-day activities. In order to comply with the Equality Act your prospective employer needs to know if you have a physical or mental impairment which may be considered a disability within the Act

The details of your disability cannot be provided to your prospective employer without your written consent. It may be helpful for them to understand the nature of your disability in order to consider what adjustments may need to be made to the workplace to help you perform your job effectively and to comply with Health and Safety.

Disability	Yes	No
Do you have any kind of chronic health condition or disablement? <i>(If yes, please answer both questions below)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Do you believe that this condition or disablement might bring you within provisions of the Equality Act 2010?	<input type="checkbox"/>	<input type="checkbox"/>

Disability	Yes	No
If yes, it will help your employer to consider any adjustments if you provide information relating to your disability/capability in the field below.		

Employment History - Please provide Job Title & dates for the last 5 years (Section F)

Job Title	Start	End
	/ /	/ /
	/ /	/ /
	/ /	/ /
	/ /	/ /
	/ /	/ /

Sickness Absence History - Please provide reason & dates for last 2 Years (Section G)

Reason	Start	End
	/ /	/ /
	/ /	/ /
	/ /	/ /
	/ /	/ /
	/ /	/ /

PART 1 (Page 5) To be completed by All Applicants

If you have answered **NO** to **ALL** of the questions in **Section D**, then please read and complete the Declaration of Fitness (**Section H**). Please return Part 1 (pages 1 to 5) to EPM Limited in an envelope addressed to EPM Ltd.

If you have answered **YES** to any of the questions in **section D**, then please read and complete in full the whole of **Part 2** and then take to your own doctor for confirmation of fitness. Any costs will need to be met by yourself.

Declaration of Fitness (Section H)

I certify that I have answered all questions in Part 1 of this form to the best of my ability and knowledge, and am able to answer **NO** to **ALL** questions in Section D. I have no reason to believe that my health will interfere with my ability to undertake the duties of the post for which I have applied, or affect my ability to give good attendance. I understand that withholding information, or knowingly giving incorrect information, about my health on this form may result in disciplinary action or dismissal.

Signed : _____

Date (dd/mm/yy) : / /

Print Name: _____

IF YOU HAVE ANSWERED YES TO ANY OF THE QUESTIONS ON PART 1, (Section D), YOU MUST NOW COMPLETE THE REMAINING SECTIONS OF THIS FORM

Based on the information you provide, Your Doctor will assess your suitability for this role and will confirm your fitness for employment to Education Personnel Management Ltd, together with any additional recommendations. Incorrect information, or information not provided may invalidate the terms of your employment. The information given on this questionnaire will be used by your Doctor and EPM only, and will not be given to anyone without your written permission.

Part 2 (A) Please indicate whether you have ever been medically diagnosed with, or treated for any of the following diseases or conditions. If so, please state your age at onset or occurrence, and provide brief details in the space provided, (you must answer Yes or No to all of the questions below).

Heart and Circulation		Yes	No	Age	
(a)	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>		
(b)	Angina	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Other heart disease, or abnormal heart rhythm	<input type="checkbox"/>	<input type="checkbox"/>		
(d)	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>		
(e)	Stroke / mini stroke (TIA)	<input type="checkbox"/>	<input type="checkbox"/>		
(f)	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		
(g)	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>		
(h)	Poor circulation, swelling of the legs, deep vein thrombosis	<input type="checkbox"/>	<input type="checkbox"/>		
(i)	Varicose veins, leg ulcers	<input type="checkbox"/>	<input type="checkbox"/>		
Respiratory		Yes	No	Age	
(a)	Shortness of breath, wheezing, troublesome bouts of coughing	<input type="checkbox"/>	<input type="checkbox"/>		
(b)	Regular cough and/or production of phlegm	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		
(d)	Asthma	<input type="checkbox"/>	<input type="checkbox"/>		
(e)	Any other lung disorder <i>(If yes, please give details)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(f)	<i>Do you smoke?</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(g)	If no, have you ever smoked?	<input type="checkbox"/>	<input type="checkbox"/>		
(h)	If yes, how long is it since you stopped?	Yrs	Mths		
Psychological health		Yes	No	Age	
(a)	Nervous breakdown, panic attacks, phobias, neurosis	<input type="checkbox"/>	<input type="checkbox"/>		
(b)	Psychosis, schizophrenia, obsessive/compulsive disorder	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Anxiety, depression	<input type="checkbox"/>	<input type="checkbox"/>		

(d)	Severe stress	<input type="checkbox"/>	<input type="checkbox"/>		
(e)	Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>		
(f)	Have you ever tried to harm yourself?	<input type="checkbox"/>	<input type="checkbox"/>		
Eyesight		Yes	No	Age	
(a)	Eye disease, infection, inflammation, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		
(b)	Glaucoma, disease of the retina	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Have you undergone any eye surgery, or have any planned?	<input type="checkbox"/>	<input type="checkbox"/>		
(d)	Any other vision defect?	<input type="checkbox"/>	<input type="checkbox"/>		
(e)	If you wear glasses or contact lenses, please give the approximate date of your last eye test with an optician?	/ / (dd/mm/yy)			
Hearing		Yes	No	Age	
(a)	Are you aware of any hearing problems?	<input type="checkbox"/>	<input type="checkbox"/>		
(b)	Non infective ear disorder (e.g. tinnitus, vertigo, giddiness)	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Infective ear disease (e.g. discharge, glue ear)	<input type="checkbox"/>	<input type="checkbox"/>		
(d)	Hearing loss (Industrial, Military or other)	<input type="checkbox"/>	<input type="checkbox"/>		
(e)	Ears, nose, throat surgery	<input type="checkbox"/>	<input type="checkbox"/>		
Musculo-skeletal		Yes	No	Age	
(a)	Upper limb shoulder, elbow, wrist, hand	<input type="checkbox"/>	<input type="checkbox"/>		
(b)	Lower limb – hip, knee, ankle, feet	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Spine – neck, thoracic, lumbar, spine (e.g. slipped disk, sciatica, recurrent back pain)	<input type="checkbox"/>	<input type="checkbox"/>		
Musculo-skeletal - continued		Yes	No	Age	
(d)	Muscle or nerve disease (e.g. Chronic Fatigue Syndrome/ME, Fibromyalgia)	<input type="checkbox"/>	<input type="checkbox"/>		
(e)	Arthritis, Gout	<input type="checkbox"/>	<input type="checkbox"/>		
(f)	Muscles or joint problem	<input type="checkbox"/>	<input type="checkbox"/>		
(g)	Fractures, injuries, surgery (If yes, please give details - where, when etc.)	<input type="checkbox"/>	<input type="checkbox"/>		
(h)	Any other severe or debilitating condition or pain? (If yes, please specify)	<input type="checkbox"/>	<input type="checkbox"/>		

Skin/nails		Yes	No	Age	
(a)	Skin diseases or conditions (e.g. eczema, psoriasis, dermatitis) <i>(If yes, please give details)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(b)	Current skin infections, bacterial, fungal (e.g. ringworm)	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Any occupational skin disorder	<input type="checkbox"/>	<input type="checkbox"/>		
(d)	Skin tumours/cancers	<input type="checkbox"/>	<input type="checkbox"/>		
Gastro-Intestinal/Abdominal		Yes	No	Age	
(a)	Hernia	<input type="checkbox"/>	<input type="checkbox"/>		
(b)	Any bowel problems (e.g. Colitis, chronic diarrhoea, Irritable Bowel Syndrome, Crohns, piles/haemorrhoids)	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Gall stones, pancreatitis,	<input type="checkbox"/>	<input type="checkbox"/>		
(d)	Jaundice or Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>		
(e)	Kidney problems, renal stones	<input type="checkbox"/>	<input type="checkbox"/>		
(f)	Chronic indigestion, stomach, peptic or duodenal ulcers	<input type="checkbox"/>	<input type="checkbox"/>		
(g)	Infections (e.g. typhoid, paratyphoid fever, salmonella, cholera)	<input type="checkbox"/>	<input type="checkbox"/>		
(h)	Recurring abdominal pains, gynaecological problems	<input type="checkbox"/>	<input type="checkbox"/>		
(i)	Severe problems with appetite or digestion	<input type="checkbox"/>	<input type="checkbox"/>		
(j)	Frequent need for the toilet or incontinence	<input type="checkbox"/>	<input type="checkbox"/>		
Blood/Metabolic disorder		Yes	No	Age	
(a)	Any blood disorder, disorder of lymph glands, anaemia, leukaemia	<input type="checkbox"/>	<input type="checkbox"/>		
(b)	Any congenital disorder manifested through the blood? <i>(If yes, please give details)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Any disease carried through the blood (e.g. Hepatitis B. Nb. It is Council policy that HIV does not have to be disclosed)	<input type="checkbox"/>	<input type="checkbox"/>		
(d)	Thyroid, pituitary or other hormone disorder	<input type="checkbox"/>	<input type="checkbox"/>		
(e)	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>		

	<i>If yes, do you require insulin injections on a strict timetable</i>	<input type="checkbox"/>	<input type="checkbox"/>		
Neurological		Yes	No	Age	
(a)	Headaches, cluster headaches, migraines	<input type="checkbox"/>	<input type="checkbox"/>		
	<i>If yes, please indicate severity(mild, moderate or severe, and how often you get them.)</i>				
(b)	Severe head injury/Concussion	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Fits, blackouts, fainting, giddy spells, loss of balance, double vision, vertigo	<input type="checkbox"/>	<input type="checkbox"/>		
(d)	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		
	<i>If yes, please give details of last attack (dd/mm/yy)</i>	/ /			
(e)	Any problems with sensation (e.g. co-ordination, weakness of muscles)	<input type="checkbox"/>	<input type="checkbox"/>		
General Medical		Yes	No	Age	
(a)	Cancer	<input type="checkbox"/>	<input type="checkbox"/>		
(b)	Have you ever had a tropical disease? (e.g. malaria)	<input type="checkbox"/>	<input type="checkbox"/>		
(c)	Other debilitating illnesses (e.g multiple sclerosis, Parkinsons disease) <i>(If yes, please give details)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
General Medical - continued		Yes	No	Age	
(d)	Do you suffer from any medical condition affecting your sleep? <i>(if yes, please give details)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(e)	Have you ever had any medical condition not mentioned above that has involved your G.P., a hospital or specialist?(If yes, please give details)	<input type="checkbox"/>	<input type="checkbox"/>		
(f)	Allergies <i>(If yes, please give details)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(g)	Operations <i>(If yes, please give details)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(h)	Are you currently taking any prescribed tablets or medication or receiving injections (excluding contraception or HRT)? <i>(If yes, please specify type and timetable)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
(i)	Would you consider yourself to be dependent upon or addicted to drugs (medication, recreational or alcohol)?	<input type="checkbox"/>	<input type="checkbox"/>		

(j)	Do you drink in excess of 21 units per week (for a male), or 14 units per week (for a female)? (If so, how many units per week? 1 unit = 1 glass of wine or ½ a pint of beer)	<input type="checkbox"/>	<input type="checkbox"/>		
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Signature

I certify that I have answered all questions to the best of my ability and knowledge. I have no reason to believe that my health will interfere with my ability to undertake the duties of the post for which I have applied, or affect my ability to give good attendance. I understand that withholding information, or knowingly giving incorrect information, about my health on this form may result in disciplinary action or dismissal.

Signed _____ date _____ / _____ / _____
 : (dd/mm/yy) :

Print Name: _____

Please complete next page

Part 2 (B)
GP/SPECIALIST REPORT

GP REPORT

It may be necessary for EPM Limited to obtain further information from your GP or Consultant before they are able to determine your fitness for work. Any reports provided will form part of your Occupational Health Medical records and will not be provided to your employer. Under the 'Access to Medical Reports Act 1998' a medical report cannot be provided by a Medical Practitioner without your consent. You have the following options regarding any report requested:

1. You may withhold your consent to a report being provided to us.
2. You may consent, but request to see the report before it is provided to us. The Medical Practitioner will then send the report to you. If you have not replied to them within 21 days of the report being sent, they may assume consent and provide the report to us. If you do not approve the report due to any information you deem incorrect, you can request in writing, that the report be amended. The Medical Practitioner may or may not agree to amend the report. If they do not you may:
 - a) I withdraw your consent to the report being issued
 - b) I request that the Medical Practitioner attach a statement from yourself to the report
 - c) I agree to the report being issued unchanged

You may also withdraw your consent to the report being provided if the Medical Practitioner declines to show you the report, or part of the report, if they consider there are special circumstances as described in the Act.

3. You may consent to the report being provided (and request a copy if you wish - up to 6 months after it has been provided).

EPM Limited will inform you of each report that is requested.

I do not consent to a medical report being provided to EPM Limited

I consent to a medical report being provided to EPM Limited, but I wish to see it before it is issued.

I consent to a medical report being provided to EPM Limited.

I would like a copy of the report Yes/No

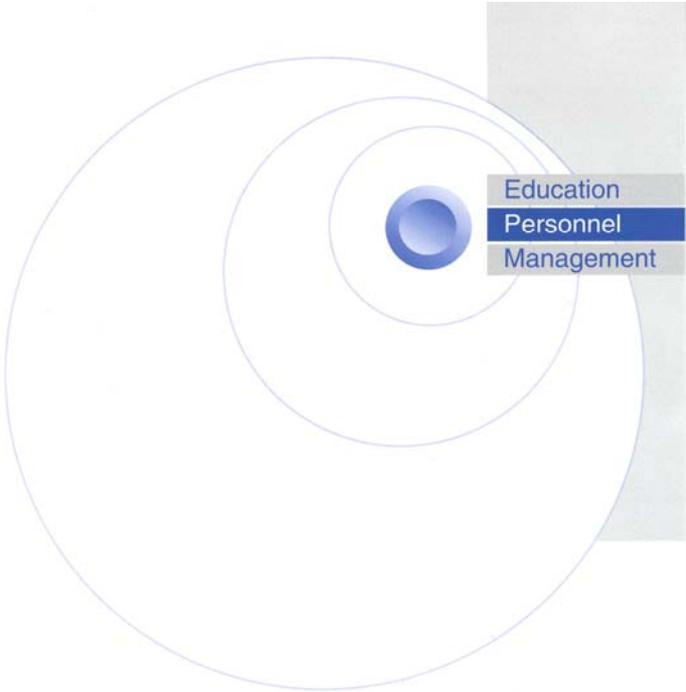
Any costs incurred will be paid for by me.

Signed _____ Date _____

Now that you have completed Parts 1 and 2, please forward to your doctor to provide a medical report to confirm your fitness for supply teaching and then return to EPM Limited with your supply application form.

EPM/MB/TH
 Date as Postmark
 01480 421791/423434

GP Name and full address (**please complete**)



Education
 Personnel
 Management

CONFIDENTIAL- PRE-EMPLOYMENT MEDICAL QUESTIONNAIRE
To be completed by your GP and returned to EPM with parts 1 & 2 together with your Supply Application form

Name of Supply Teacher: _____ Date of Birth: _____
 Full Address: _____
 _____ Postcode: _____

Date of appointment			
Additional information obtained	GP		Specialist
Please list/state nature of report (s) received			
Does the employee have a physical or mental impairment	Yes		No
If yes, has the employee consented to the nature of their impairment being stated to the employer	Yes		No
Is the impairment temporary or permanent	Temp		Permanent
Is the employee fit for the job described?	Fit		
	Limited Capability (please provide further details)		
	Not Fit		
	Insufficient Information		
Should reasonable adjustments be considered to enable the employee to start work. If yes, please list comments below.	Yes		No
Are there any health risks from previous employment, medical conditions or past history that may affect the employee future work?	Yes		No
Comments (if necessary continue on separate Sheet):			

Practitioners Name: _____ Signature: _____

I consent to this medical report being provided to EPM Limited YES/NO
 I will retain a copy of the report YES/NO
 Any costs incurred will be paid for by me.

I can confirm that the above information was supplied by my GP and has not been amended in any way.

Supply Teachers Signature: _____

Date: _____