

Application forms

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CONFIDENTIAL health questionnaire

1a

PLEASE NOTE: failure to fully complete this health declaration will result in it being returned to you and may delay your start date.

PERSONAL DETAILS

Surname: Forenames:

Previous surnames: Mr/Mrs/Miss/Ms/Dr:

Date of birth: Male Female NI no.:

Current address:

..... Post code:

Tel: Mobile: E-mail:

General practitioner Dr: Tel:

Have you ever been health screened for employment within the NHS? Yes No

If yes, give details of last post/location and date of leaving:

Will the post involve exposure prone procedures (i.e. surgical/invasive procedures)? Yes No Not sure

PROGRAMME APPLIED FOR:

We are committed to a policy of equal opportunities and in particular recognise the duties specified in the Disability Discrimination Act. We seek to offer employment and volunteer opportunities appropriate to physical or mental disability when possible, as long as the disability does not compromise the health and safety of employees, other workers or patients.

The questions that follow are asked to determine functional capacity and fitness for work and to assist in identifying reasonable adjustments to accommodate someone with a disability.

The information in this form will be kept strictly confidential within the Occupational Health Service and will not be used or disclosed to any other person without the written consent of the person to whom the information relates. This completed form is a confidential document and should be placed in the addressed envelope provided, sealed and returned directly to the Occupational Health Department.

For Occupational Health Service use only

From the information provided, this person appears FIT for employment Yes No

Occupational Health Service to see Yes No If **yes**, prior to start date Yes No

The above has attended for health screening and appears FIT for employment Yes No

Signature: Date:

HEALTH/MEDICAL INFORMATION

Please tick the appropriate Yes or No box for the following questions and **give details as fully as you can**. Useful details to include would be:

- When did the problem occur?
- How long did it last?
- What type of treatment did you receive?
- Were you treated by your GP, seen in outpatients or admitted to hospital?
- Were you unable to work or prevented from carrying out normal daily activities?
- Does the condition still affect you in any way?

Question	No	Yes
1. Do you have, or have you ever had, any medical conditions or operations?		
2. Are you receiving any pills, tablets, inhalers, injections or other treatment at the moment (including GP prescribed, herbal, self-medication, physiotherapy)?		
3. Have you ever suffered a work-related illness or given up work because of ill health?		
4. Have you ever had any physical limitation which might affect your ability to work (including vision or hearing)? If yes, have you had any workplace adjustments for this during previous employment?		
5. Have you ever had any kind of back, joint or muscle problem? If yes , did it lead to time off work?		
6. Have you ever had: a. A skin problem? b. Any allergies? c. A persistent cough, unexplained weight loss or fever in the past 12 months?		
7. Have you ever had any mental illness which might affect your ability to work (including anxiety, depression, self-harm, eating disorders, psychological or emotional problems)? If yes , have you had any workplace adjustments for this during previous employment?		
8. Have you ever had a drug or alcohol problem which has affected your work?		
9. Have you returned from living or working abroad in the past year?		
10. Have you had any days away from study or work due to illness or injury in the last two years? Below, please give number of days and reasons to the best of your recollection.		

Question	Additional details

NB: if any information is given falsely or has been deliberately omitted, you may be regarded as ineligible for employment or liable to be dismissed.

VACCINATION/DISEASE HISTORY

Have you had any of the following diseases? Please complete, giving exact dates where possible.

- Measles** Yes No Date:
- German measles (rubella)** Yes No Date:
- Chicken pox (varicella)** Yes No Date:
- Hepatitis C** Yes No Date:
- Tuberculosis** Yes No Date:

Have you received any of the following vaccinations or tests? Please complete, giving exact dates where possible.

- Hepatitis B vaccine** Date (1): Date (2): Date (3):
- Antibody test Yes No Date
- Five-yearly booster Yes No Date
- How many doses of hepatitis B vaccine have you had in total? doses
- Are you known to have had a previous infection with hepatitis B virus (had the disease)? Yes No
- Are you known to be a carrier of the disease? Yes No If **yes** Low infectivity High infectivity

- BCG vaccine** Yes No Date: Scar present Yes No
- Measles antibody** Yes No Date: Result:
- German measles (rubella) antibody** Yes No Date Result:
- MMR vaccine** Yes No Date (1): Date (2):
- DTP vaccine** Yes No Date (1): Date (2): Date (3):
Date (4): Date (5):
- Chicken pox (varicella) antibody** Yes No Date: Result:

These three questions must be completed by EPP workers only

- Hepatitis B antigen** Yes No Date: Result:
- Hepatitis C antibody** Yes No Date: Result:
- HIV antibody** Yes No Date: Result:

DECLARATION

I confirm that the information given on this form is correct to the best of my knowledge. I understand that if any information is false or has been deliberately omitted, I may be regarded as ineligible for employment or liable to be dismissed. I understand that medical details will not be divulged without my permission to any person outside the Occupational Health Service, but an opinion about my fitness to work will be given to management.

I agree that the Occupational Health Service can (please tick relevant boxes)

- 1. Obtain my occupational health record from any other NHS organisation
- 2. Obtain my immunisation and screening results from any other NHS organisation
- 3. Transfer my immunisation and screening results to other NHS organisations where I am working, where I intend to work, or where I will be on placement or part of a rotational training post.

Signature:

Date:

PRINT name:

GP declaration form



THIS FORM SHOULD BE TAKEN WITH THE ATTACHED HEALTH QUESTIONNAIRE FOR COMPLETION BY YOUR GP BEFORE BEING RETURNED IN A SEALED ENVELOPE TO THE OCCUPATIONAL HEALTH DEPARTMENT

Name of applicant (*PRINT*):

Date of birth: Job title:

Address:

.....

I hereby give my consent for the occupational health department to contact my general practitioner, consultant or other healthcare provider as necessary to obtain information about my health status relevant to my application for this post.

Signature: Date:

DECLARATION BY GENERAL PRACTITIONER

1. How long has this person been registered with you as a patient?

2. How far back do your medical records go on this patient?

3. Has this person ever suffered from any mental health problems – depression, nervous breakdown, anxiety, self-harm, anorexia, bulimia, stress or psychological problems?

.....

4. Would you be willing to supply further information if requested to do so, where appropriate consent is supplied?

.....

I have read the health questionnaire form of the person named above. I confirm its accuracy to the best of my knowledge.

Signature of doctor: Date:

Doctor's name: (*PRINT*):

Surgery stamp:

**Please attach this form to the confidential health questionnaire.
Candidates are responsible for any fee payable.**

please tear along the perforated line

Occupational health confirmation form



Pre-registration midwifery, nursing and paramedic science programmes

Please complete these details and return the form to the address below.

Student name:

Programme:

Programme start date:

I confirm that I have completed the confidential health questionnaire and GP declaration form and have returned them to one of the departments listed below:

Darent Valley Hospital Dartford

Queen Elizabeth Hospital Woolwich

Queen Mary's Hospital Sidcup

Princess Royal Hospital Bromley

PLEASE CIRCLE AS NECESSARY

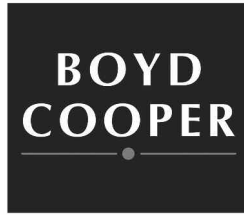
Return this confirmation form (**NOT** your health questionnaire) to:

Student Centre
University of Greenwich
Avery Hill Road
Eltham
London SE9 2UG

Failure to return this form may delay you starting your programme.

Uniform order form

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Boyd Cooper - Dimensions Corporatewear – 2 Boundary Court, Willow Farm Business Park, Castle Donington DE74 2NN
Telephone: 01332 856 951 Fax: 01332 856 950 E-mail: enquiries@boydcooper.com

UNIVERSITY OF GREENWICH – STUDENT ORDER FORM

Style	Colour	Sizes	Length	Qty	Size req.	Price each inc. VAT	Total
Dress DF1590027	Pale grey/white trim	8–26	Unhemmed			£16.08	
Dress DF1590027	Pale grey/white trim	8–26	42"			£16.44	
Dress DF1590027	Pale grey/white trim	8–26	44"			£16.44	
Dress DF1590027	Pale grey/white trim	8–26	46"			£16.44	
Female tunic FT1590020	Pale grey/white trim	8–26	30"			£15.52	
Female trousers LT2000011	Black	8–26	Unhemmed			£15.26	
Male tunic GT7460002	Pale grey	30–50	31"			£15.26	
Male trousers MT6000020	Black	28–44	Unhemmed			£18.94	

please tear along the perforated line

A sizing chart has been included overleaf to help you to ascertain your correct size.

£

Student name: *PLEASE PRINT USING BLOCK CAPITALS*

Declaration: I confirm that the above items indicated are given as correct sizes.
Returned items: garments dispatched in accordance with the specified order and returned for replacement will be subject to a carriage charge.

Signature: Date:

Delivery address:
.....
.....

Daytime telephone no.:

NOW PLEASE COMPLETE THE PAYMENT FORMS OVERLEAF

Please note: goods cannot be despatched until payment is received. Therefore, please ensure that all relevant sections are completed. Failure to do so may result in your order being delayed unnecessarily.

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METHOD OF PAYMENT

Cheque
 Access/MasterCard
 Visa
 Switch

Card no.:

Issue no.:
 Expiry date: -
 Total £.....

Security code: (Last three-digit number found on the signature section of card).

Please make all cheques payable to **'BOYD COOPER'**. Please write the cheque guarantee card number on the reverse of the cheque.

Cardholder's name: PLEASE PRINT USING BLOCK CAPITALS

Please allow four working days for cheques to clear. Goods will only be dispatched upon receipt of full payment.

BODY MEASUREMENT CHART – CONVERSION TABLE

Size Female	8	10	12	14	16	18	20	22	24	26	28	30	32	34	36
Bust (inches)	30	32	34	36	38	40	42	44	46	48	50	52	54	56	58
Waist (inches)	22	24	26	28	30	32	34	36	38	40	42	44	46	48	50
Hips (inches)	32	34	36	38	40	42	44	46	48	50	52	54	56	58	60

Size Male									
Chest (inches)	34	36	38	40	42	44	46	48	50
Waist (inches)	28	30	32	34	36	38	40	42	44

Please return this order form to Boyd Cooper (address shown overleaf) and retain a copy for your reference.

