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+44 7 403 368 608
info@pandghealthcare.co.uk

HEALTH DECLARATION

CONFIDENTIAL

This health screening is undertaken in order to limit the risk of your health being detrimentally affected by your work and to ensure you are fit to undertake the duties of the role for which you have applied.

The information is assessed by P & G Healthcare Agency Ltd or an appropriate appointed agency, who will advise P & G Healthcare Agency on your fitness to practice. P & G Healthcare Agency may disclose this to clients for the purpose of finding you a suitable assignment.

Information contained within this occupational Health declaration form is governed by the Data Protection Act 1998.

You may be contacted by the P & G Healthcare Agency (YCA) appointed health department for further information, or be asked to attend a medical examination.

Please ensure this form is completed fully and accurately.

Personal Details			
Surname:	First name:		
Middle Name:	D.O.B:	Gender: M / F	
Address:			
Contact Numbers:	H:	M:	W:
Email:			

Post Applied For		
Exposure prone Procedures	☐ Yes	☐ No
Do you consider that you are in good health at present?	☐ Yes	☐ No
If, No, please give details below:		

Do you wish to carry out Night Work?	☐ Yes	☐ No

To be completed Internally Division: RGN/RMN/Care Home

Tuberculosis Information

Please tick the appropriate box. If 'yes' give details in the righthand column with dates where applicable and return along with the required immunisation proof to info@pandghealthcare.co.uk

Name:	D.O.B:
Signature:	Date:

Have you ever received a BCG vaccination?	☐ Yes	☐ No
Do you have or ever had tuberculosis (TB)?	☐ Yes	☐ No
Have you been in close contact with anyone suffering from tuberculosis?	☐ Yes	☐ No
Do you have persistent cough?	☐ Yes	☐ No
Do you have night sweats or a fever?	☐ Yes	☐ No
Do you have unexplained weight loss	☐ Yes	☐ No
Please state your country of birth?		
Have you lived or travelled outside of the EU in the last 5 years? (If yes, please give dates and countries visited)	☐ Yes	☐ No

Countries Visited	From			
	Month	Year	Month	Year

Please provide evidence of immunity to TB

- Those who are not immunized against TB must provide evidence of a NEGATIVE Mantoux test or Chest X-ray (CXR) or Quantiferon/Gold Spot Test (interferon – gamma testing) within the last 12 months.

- Those who have lived in a Tuberculosis High Risk Country >3 consecutive months in the last 5 years **must provide** evidence of a Mantoux/CXR /Quantiferon test since being in that country.

Reference

Health clearance for Tuberculosis, Hepatitis B, Hepatitis C and HIV; Department of Health 2007

http://publications.nice.org.uk/tuberculosis-cg117/introduction

http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1195733837507

Please tick the appropriate box – if 'yes' give details in the right hand column with dates where applicable

Will you require any special adjustment in your working				
Have you had chickenpox or shingles?				
Have you been unable to work because of ill-health for longer than 2 weeks in the past 2 years?				
At present are you receiving any medical treatment / medication/ therapies?				
Have you had operation, illness or injuries, which required hospital treatment or investigations in the past 12 months?				
Do you have any allergies, including latex?				
Do you have any skin problem, irritation, infection or disease?				
Do you have any neck, back, shoulder or joint problems?				
Do you have any problems with your vision, hearing or speech?				
Do you suffer from any mental health problem that has required medication or any form of treatment?				
Is there anything else in relation to your health you wish to disclose?				
Have you travelled to any countries affected by Ebola (currently, Guinea, Sierra Leone and Liberia) in the last 21 days? (If yes, give details in the right hand column where applicable)				
Date from:	To:	Country:		Holiday/work (delete as applicable)

Declaration
I confirm that I have read this document fully and that all the information given to P & G Healthcare Agency Ltd is correct to the best of my knowledge and belief. I am aware of the need to protect patients/residents and myself and agree to notify P & G Healthcare Agency Ltd if any circumstances alter. I give my permission for P & G Healthcare Agency Ltd to contact my GP or specialist to seek further information on any aspect of the information contained within this health statement. I understand that the information contained in this form is sensitive personal data within the meaning of the Data Protection Act 1998 and that in signing this form I am agreeing to P & G Healthcare Agency Ltd processing my data as detailed in this form. I confirm that I consent to a copy of my fitness certificate declaring my fitness to work and containing information on my immunity status being sent to any client of P & G Healthcare Agency Ltd to whom I may seek assignments from time to time.

Print Name:	
Signature:	Date:

DRUG CALCULATION TEST *(Nurses only)*

The majority of our NHS and private clients require us to obtain written evidence of your involvement in the administration of medicines.

Please answer all of the following questions below. You are permitted to use a calculator. Once completed please sign and return it at interview stage. The completed test will be held on your personal file. P & G Healthcare Agency is licensed under the Data Protection Act.

1	A patient requires 500mg flucoxacillin; you have 200mg in 1ml syrup. How much do you give?	
2	A patient weighs 70kg. It has been decided that they must have 6mg per kg of ibuprofen. How much is to be given?	
3	A patient requires 50mg of risperidone. You have 25mg in 10mls syrup. How many mls should be administered?	
4	A patient requires 0.25g of clarithromycin, 250mg tablets are available. How many tablets are needed?	
5	A patient requires 125mg pethidine by intramuscular injection, 50mg in 1ml available. How many mls will you administer?	
6	A patient is prescribed 125mcg of digoxin. You have 62.5mcg tablets. How many tablets do you need?	
7	A patient requires 5mg diazepam. You have 2mg in 5ml suspension. What amount is required?	
8	A patient requires 1.5g amoxicillin. It is available in 500mg tablets. How many tablets do you need?	
9	A patient requires 50mg amoxicillin orally. 125mg in 5ml syrup available. How many mls will you give?	
10	A patient requires 75mg pethidine by intramuscular	

	injection. 50mg in 1ml available. How many mls will you administer?	

Declaration	
Signature	Part of Register:
Print full name:	Registration number:
Initials:	Expiry Date: / /