



**PRE-WORK HEALTH ASSESSMENT**

**OccHealth**

**Section One: To be completed by Manager / HR**

**Please note If Section One is incomplete the assessment will NOT be processed**

**COMPANY DETAILS**

Name of company			
Name of recruiting manager/HR		Contact number	

**PREFERRED CANDIDATE DETAILS**

First name(s)		Surname	
Job Title		No. of hours	

Please identify workplace hazards applicable to this role.

Job hazards	Tick if applies	Job hazards	Tick if applies
Display Screen Equipment		Shifts / night work	
Driving role, please circle: <i>HGV PCV Mechanical Handling Equipment</i>		Respiratory irritants/chemicals/dusts	
Lone working		Prolonged/static postures	
Working at height		Skin irritants ( <i>COSHH</i> )	
Vibrating tools		Bending, kneeling, squatting, stretching	
High pressure / demands / deadlines		Physical restraint	
Exposure to noise above 80db		Lifting/carrying objects greater than 5kg	
Making repetitive movements		Other, please state:	
Confined space work			
Pushing/pulling objects greater than 10kg			

**Section Two: To be completed by the candidate**

First name(s)		Surname	
Title		Date of Birth	
Contact number			
Address (and postcode)			
Email address			



## PWAHA

<b>Name:</b> .....		<b>Date of Birth:</b> .....	
<b>Please answer YES or NO in the appropriate column. Occupational Health may contact you in confidence to discuss any 'yes' responses.</b>			
No	Question	YES	NO
1	Do you have any medical condition / illness which might impact on your ability to perform your new job role? (either physical and/or mental health conditions)		
2	Do you think you might need support or adjustments to assist you in your new job role?		
3	Are you currently receiving or waiting for any medical treatment? (including taking medication for any health issue)		
4	Have you ever had any health conditions which have been caused or made worse by your work?		
5	Do you have any allergies or sensitivities that could be affected by your workplace?		

## DECLARATION

I certify that the answers to the above questions are true and complete to the best of my knowledge.

I agree to attend a health assessment and comply with a health surveillance programme if necessary.

I understand that an opinion about my fitness to work will be given to HR / Management.

Signed ..... Date .....

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*These records will be held by Workplace Wellness Services electronically and /or in paper format for legislative purposes in line with the requirements of the Data Protection Act 1988. We do not share individual data with third parties.*

Please follow your employer's instructions for returning this form. There will be three possible options:

**1. Return** directly to your HR/Manager, in a sealed envelope.

**2. Post** Workplace Wellness

St Margaret's Surgery  
29 Bridge Street  
Bradford on Avon  
BA15 1BY

**3. Email** [info@workplacewellness.health](mailto:info@workplacewellness.health)