PRE EMPLOYMENT HEALTH SCREENING QUESTIONNAIRE

Private and Confidential

The purpose of this form is to obtain initial information regarding any injuries, diseases or disabilities that may affect your employment. This Information is used for the purpose of employment at St John of God Health Care (SJGHC) only and if retained is maintained as private and confidential.

PERSONAL DETAILS

Male Female ☐

Surname:	Other Names:
Title of Position Applying For:	
Address: Post Code:	Preferred Telephone Contact no:
Email Address:	
Have you worked at St John of God Health Care previously: ☐ Yes ☐ No If Yes, indicate which division:	

HEALTH AND WORKERS COMPENSATION

St John of God Health Care (SJGHC) is an Equal Employment Opportunity employer, therefore a disease, injury or disability is not a barrier to the consideration of an application for employment. Offers of employment are conditional upon the applicant first being assessed as being fit to safely undertake the duties of the proposed position without placing yourself or others at a risk of injury. Please answer all questions truthfully. Failure to disclose relevant information may result in your contract of employment being revoked. Wilful and false representation, at the time of seeking or entering employment, about previously suffered disabilities may result in the refusal to award compensation which otherwise would be payable.

[Section 79 of the Workers' Compensation & Rehabilitation Act 1981].

SJGHC will contact you if further information or a medical examination is required. Failure to attend an appointment for the medical examination may result in a contract of employment not being offered or being revoked.

1. Height cm Weight kg

Office Use BMI =

2. Smoking ☐ Never ☐ Currently ☐ Quit

   Age Started Age Quit Amount cig/day

3. Are you currently being treated by a doctor or health professional for any illness or injury? ☐ Yes ☐ No

   If Yes, provide details

4. Are you currently receiving any medical treatment or taking medication? ☐ Yes ☐ No

If Yes, provide details

5. Have you ever made a claim for workers' compensation? ☐ Yes ☐ No

If Yes, please provide details of when the claim was made and for what disease / injury the claim was made.

6. If yes, have you finalised this workers' compensation claim? ☐Yes ☐No

If Yes, please provide details of settlement / finalisation.
If No, please provide details of the current claim.

7. Are there any reasons that you may not be able to physically or mentally perform the duties assigned to you? ☐ Yes ☐No

If Yes, please provide details.

8. Do you have a medical condition which may be aggravated or could recur due to the type of work, or the environment, for which you are applying? ☐ Yes ☐ No

If Yes, please provide details.

PERSONAL HEALTH HISTORY Please answer "yes" or "no" to the following questions.

	YES	NO		YES	NO
1. Do you have any physical disability?	☐	☐	15. Have you ever had rheumatics or arthritis of any kind?	☐	☐
2. Do you have any visual problems?	☐	☐	16. Have you ever had any allergies?	☐	☐
3. Do you have difficulty hearing or with balance?	☐	☐	17. Have you a tendency to bruise or bleed excessively?	☐	☐
4. Have you had any back /neck trouble or pain	☐	☐	18. Have you ever had persistent headaches?	☐	☐
5. Have you had an injury of any kind?	☐	☐	19. Have you had a hernia?	☐	☐
6. Have you had any bone fractures or dislocations?	☐	☐	20. Have you ever suffered from whiplash?	☐	☐
7. Have you had any knee trouble/pain?	☐	☐	21. Do you have any blood or body fluid borne disease?	☐	☐
8. Have you had any ankle trouble/pain?	☐	☐	22. Do you have difficulty working at heights or in confined spaces?	☐	☐
9. Have you had any skin rashes/problems?	☐	☐	23. Do you have heart trouble or experienced chest pain?	☐	☐
10. Have you had shoulder/elbow or wrist trouble/pain?	☐	☐	24. Have you had seizures/fits or fainting?	☐	☐
11. Have you ever been exposed to noise in previous employment? If yes, was hearing protection used?	☐ ☐	☐ ☐	25. Have you had any psychological or psychiatric problems i.e. anxiety, depression, stress, panic attacks etc?	☐	☐
12. Have you had health effects from chemicals you have contacted in the past?	☐	☐	26. Have you had RSI, Overuse Syndrome or Carpal Tunnel Syndrome?	☐	☐
13. Is there any reason you can't wear safety or protective equipment (ie. safety boots, ear muffs, glasses)?	☐	☐	27. Do you have shortness of breath or suffer from breathing difficulties?	☐	☐
14. Do you attend a physiotherapist, chiropractor or osteopath?	☐	☐	28. Have you ever had tuberculosis?	☐	☐
			29. Have you a latex allergy, or, as suspected latex allergy?	☐	☐

Please elaborate with further details regarding each of the YES answers in Personal Health History (prior question).

Q	Year	Problem	Treatment/surgery	Any ongoing problems, treatments, or issues?

PRIVACY

Medical information is subject to the Commonwealth Privacy Act and there are strict requirements relating to confidentiality. Medical information may, only by necessity, be disclosed with the written permission of the person concerned.

CERTIFICATION

I certify that the information in this application form is to the best of my knowledge and belief, true and accurate in every detail. I agree to abide by the rules and regulations of SJGHC and understand that SJGHC reserves the right to verify all information on this application and that any false statements will be considered sufficient cause for rejection as an applicant or my dismissal if hired.

I agree that the Occupational Safety and Environment Department may communicate with my medical practitioner(s) or health care provider, who is/are hereby authorised to divulge any relevant information concerning my health. I also acknowledge that any false information may be grounds for the rejection of any future workers' compensation claim in accordance with relevant workers compensation laws. I also agree to undergo a medical examination at SJGHC expense if so required. I have no objection to the results of such tests being made available to SJGHC.

Signed _____ Date ____/____/____