The purpose of this form is to identify people who apply to work or volunteer for St John Ambulance who have health conditions that may affect their ability to carry out their role(s). The information you provide will also enable St John Ambulance to assess whether any workplace adjustments are necessary to assist you in performing your volunteer or employee activities safely and effectively.

The form is also used for existing volunteers and employees who change their role, or have had a change in their health status. In that case, for "applicants" read "volunteers and employees".

Young people under 14 enrolling to be Badgers or Cadets should complete a different form

"Health Declaration – Cadets (under 14) and Badgers"

Instructions

This form is split into four sections:

Section 1 is to be completed by **all applicants**
Section 2 consists of two parts: **Part A** is to be completed by Office at Erne **Part B** is to be completed by Area or District St John Ambulance Medical Officer.
Section 3 is to be completed by **all applicants whose role will require patient contact, manual handling and/or driving**. It consists of three parts: **Part A** is to be completed by applicants whose role requires **patient contact, manual handling and/or driving** **Part B** is to be completed **by applicants who will have direct contact with patients** **Part C** is to be completed **by applicants whose role will include driving** a St John Ambulance vehicle
Section 4 is to be completed by **all applicants**

The completed form will be treated as confidential and stored securely by St John Ambulance. It will be accessed only by authorised personnel at Office at Erne and by the Medical Officer appointed to review health declarations on behalf of St John Ambulance.

Should it be necessary to obtain further information in response to the answers given, a supplementary health declaration will be requested. This will be treated in confidence and will only be reviewed by authorised healthcare personnel.

Section 1 Basic information *To be completed by all applicants*	
Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other (please state):	
Date of birth:	☐ Male ☐ Female
Surname:	First name:
Address:	
Postcode:	Telephone no:
Mobile no:	Pager no:
Email:	
Unit/Area/District:	Erne/Employee
Position/role(s):	
Do you currently suffer from any illness or disability that may require workplace adaptations? ☐ Yes ☐ No	

Section 2 Outcome	Official use only
Part A To be completed by Office at Erne after the applicant has completed the form	
Select the relevant check box	**Action**
☐ One or more boxes have been left unchecked in section 3 and/or 4	Return form to applicant and request they fill in required fields
☐ No YES boxes checked (other than immunisations and driving licence section)	Fit for all roles
☐ One or more YES boxes checked (other than immunisations) and/or further details have been provided	Refer for clinical review
Name:	Position:
Signature:	Date:
Part B Clinical recommendations *To be completed by the Area/District Medical Officer*	
Role/job description(s) provided? ☐ Yes ☐ No Supplementary questionnaire reviewed? ☐ Yes ☐ No	
Medical examination by occupational health doctor recommended or report from GP needed? ☐ Yes ☐ No	
Recommendations *Please select one option* ☐ Fit for role(s) ☐ Suitable for role(s) but with restrictions/adaptations to working practice or environment (eg. no heavy lifting/regular breaks needed - provide details in the 'Additional notes' section below) ☐ Not fit for role(s)	
Additional notes:	
Name:	Position:
Signature:	Date:

Section 3 Health status declaration

Official use only

Part A General

To be completed by all applicants whose role will require patient contact, manual handling and/or driving (e.g. trainers, first aiders, ETAs, HCPs)

1	Do you have any illness, condition or impairment (physical or mental) which may affect any of the following?		
	a	Your ability to work	☐ Yes ☐ No
	b	Your ability to care for others	☐ Yes ☐ No
	c	Your ability to lift	☐ Yes ☐ No
	d	Your ability to bend	☐ Yes ☐ No
	e	Your ability to kneel	☐ Yes ☐ No
	f	Your ability to see, hear or speak	☐ Yes ☐ No
	g	Your ability to climb one 13-step flight of stairs	☐ Yes ☐ No
	h	Your stamina (defined as being able to walk at your own pace on level ground without stopping for at least 15 minutes)	☐ Yes ☐ No
2	Do you have any medical condition or disability which may cause you to pose a risk to your colleagues or members of the public?		☐ Yes ☐ No
3	Are you having or waiting for treatment or investigations (including medical or surgical treatment, eg. surgery, heart stress test, EEG) that may affect your work?		☐ Yes ☐ No
4	Have you at any time experienced any fits, faints, seizures, blackouts or epilepsy?		☐ Yes ☐ No
5	Are you taking any prescribed medication or any medication that you have bought for yourself (including herbal remedies)?		☐ Yes ☐ No
6	Have you had any other illness, infection, serious injury or operation not mentioned above?		☐ Yes ☐ No

Part B Immunisation and infection screening

To be completed by all applicants whose role will require patient contact (e.g. first aiders, ETAs, HCPs)

1	Have you ever had a positive test for any of the following?		
	a	Any blood borne virus, eg. HIV, Hepatitis B or C	☐ Yes ☐ No
	b	Tuberculosis (determined by Heaf test or Mantoux test)	☐ Yes ☐ No
2	Have you ever had the following immunisations?		
	a	BCG	☐ Yes ☐ No
	b	Tetanus	☐ Yes ☐ No
	c	Hepatitis B	☐ Yes ☐ No
	d	Measles	☐ Yes ☐ No
	e	Mumps	☐ Yes ☐ No
	f	Rubella (or if you have not had the immunisation do you know that you are rubella immune?)	☐ Yes ☐ No
	g	Polio	☐ Yes ☐ No

Section 3 Health status declaration

Official use only

Part C Driving

Only to be completed by all applicants whose role will involve driving a St John Ambulance vehicle

If you answer YES to any question from 2 to 10 it doesn't necessarily mean that your ability to drive is affected, but we may conclude it is not appropriate for you to drive St John Ambulance vehicles (for example compliance with DVLA guidance)

1	What sort of driving licence do you hold?		
	a	Ordinary driving licence	☐ Yes ☐ No
	b	PSV/HGV (Group 2) licence	☐ Yes ☐ No
2	**a**	Have you ever needed to contact the DVLA regarding your health?	☐ Yes ☐ No
	b	Is your driving licence restricted for medical reasons? ☐ One year ☐ Three years ☐ Five years	☐ Yes ☐ No
3	**a**	Do you, or have you suffered from epilepsy: eg. a tendency to have seizures (fits or other seizures) past the age of five?	☐ Yes ☐ No
	b	If YES, have you been seizure (or fit) free and off all anti-seizure medication for 10 years?	☐ Yes ☐ No
4	*4a-4d SHOULD ONLY BE COMPLETED BY PEOPLE WITH DIABETES*		
	a	Do you, or have you suffered from any of the following?	
		1 Diabetes requiring treatment with insulin for at least four weeks	☐ Yes ☐ No
		2 Diabetes treated with medication other than insulin	☐ Yes ☐ No
		3 Any hypoglycaemic (low blood sugar) event requiring help from another person while driving, in the last 12 months	☐ Yes ☐ No
	b	Have you had any laser eye treatment?	☐ Yes ☐ No
	c	Do you keep detailed recordings of your blood glucose measurements (twice a day at times appropriate to driving St John Ambulance vehicles)?	☐ Yes ☐ No
	d	Do you attend a diabetic clinic annually?	☐ Yes ☐ No
5	Have you ever been advised not to drive because of eye problems?		☐ Yes ☐ No
6	Do you, or have you suffered from any of the following neurological problems?		
	a	Any chronic neurological disorders (including multiple sclerosis, Parkinsonism, motor neurone disease)	☐ Yes ☐ No
	b	Any sudden attacks of dizziness, vertigo, unsteadiness or sleepiness (including Ménière's disease, sleep apnoea, narcolepsy or cataplexy)	☐ Yes ☐ No
	c	Stroke (CVA), mini-stroke (TIA) or bleeds in the head eg subarachnoid haemorrhage (including transient loss of vision in one eye, known as amaurosis fugax)	☐ Yes ☐ No
	d	Brain tumour or any other brain abnormality	☐ Yes ☐ No
	e	Head injury resulting in loss of consciousness or requiring hospital admission in the last 10 years	☐ Yes ☐ No
7	Have you had neurosurgery for any reason?		☐ Yes ☐ No

8	Do you, or have you suffered from any of the following cardiovascular problems?		
	a	Angina or heart attack (MI)	☐ Yes ☐ No
	b	Angioplasty, stent insertion coronary artery bypass grafting (CABG) or any other cardiac procedure including pacemaker insertion or ablation	☐ Yes ☐ No
	c	Peripheral arterial disease (excluding Buergers' disease) or claudication eg Raynauds disease	☐ Yes ☐ No
	d	Aortic or thoracic aneurysm	☐ Yes ☐ No
	e	Abnormal heart rhythm (including atrial fibrillation) including the insertion of pacemakers	☐ Yes ☐ No
	f	Heart failure (CCF)	☐ Yes ☐ No
	g	High blood pressure (hypertension)	☐ Yes ☐ No
	h	Inherited conditions (including Marfan's syndrome, hypertrophic obstructive cardiomyopathy (HOCM), congenital heart disease)	☐ Yes ☐ No
	i	Any other cardiac surgery or cardiac investigations	☐ Yes ☐ No
9	Do you, or have you ever suffered from any of the following?		
	a	Any mental illness requiring treatment with medication that may cause impairment of concentration or drowsiness	☐ Yes ☐ No
	b	Dementia or learning/developmental/behavioural disorders	☐ Yes ☐ No
	c	Alcohol or drug misuse or dependency	☐ Yes ☐ No
10	Do you, or have you ever suffered from any of the following conditions?		
	a	Sleep apnoea	☐ Yes ☐ No
	b	Metastatic cancer	☐ Yes ☐ No
	c	Any other condition not mentioned above	☐ Yes ☐ No

Section 4 Declaration and consent for further information

To be completed by all applicants

The information provided by you in this form is to enable an assessment to be made of your general health and fitness, in relation to your role. Your data will be stored in accordance with the Data Protection Act (1998). Please note that any information remains confidential to the medical officer or nominated individual. Further information may be requested from your GP with your permission and this will be used for clarification of some of the information you have provided. Please read the following statements, check the boxes and sign below

☐ I declare that the information provided on this form and any attachments is true, honest and complete to the best of my knowledge and belief

☐ I declare that no information has been withheld which may influence any decision regarding my ability to carry out my role or roles

☐ I declare that no information has been withheld that would be considered as a potential risk to my ability to safely drive a St John Ambulance vehicle (applicable to those applying for driving roles only)

☐ I agree that I will notify St John Ambulance of any changes to my health

☐ I understand that false or misleading information could lead to my employment or volunteer role with St John Ambulance being terminated

Signed:	Date: