

HEALTH DECLARATION

(CONFIDENTIAL)

The following information is required to assist MidCentral DHB to meet its obligations under the Health and Safety in Employment Act (and any subsequent amendment or replacement legislation) and to assess your ability to fulfil the requirements of the position.

HEALTH DECLARATION FOR THE POSITION OF _____
(To be completed by shortlisted applicants)

Please complete all sections of this form and sign the declaration at the end of the form (Section 4).

SECTION 1

I, (Full Name) _____ have read the job description and position competencies for the above position. In particular, I have noted the **“Physical Attributes”** section.

I declare that either (tick one box):

I have no health condition or disability which would prevent me from undertaking the requirements of this position in a manner which is safe for me and others.

OR:

I have the following health condition or disability which will either **limit my ability to undertake the requirements of this position, or which will require adaptations to the workplace or work procedures** to enable me to undertake the requirements of this position in a manner which is safe for me and others:

SECTION 2

I have / have not (delete one) had any health problems which:

- May be aggravated by my working at the job for which I am applying.
- May reduce my ability to carry out efficiently all the duties required of me.
- This includes any health problems which have resulted from any accidental injury or other health condition accepted by ACC as caused by disease or infection, such as (but not limited to) noise induced hearing loss, back problems, musculoskeletal problems, OOS (occupational overuse syndrome), chemical sensitivity in the form of dermatitis, allergies, respiratory problems, latex allergy.

I am / am not (delete one) taking any medication/having treatment which has side effects, eg drowsiness, slowed reaction times, which may reduce my ability to carry out safely and efficiently all the duties required of me.

The injury or health condition/treatment is:

The workplace arrangements that would be required to enable me to perform this position are listed below:

SECTION 3

Staff Vulnerability and Vaccination Status

In line with national guidance, MDHB is asking ALL NEW STAFF to complete this section to capture information regarding staff with underlying health conditions and their COVID-19 vaccination status in order to allow the DHB to deploy them safely in a pandemic situation, including but not limited to COVID-19.

All information about your health captured through this form will remain confidential and will be accessed by the Occupational Health team only for the purposes of assessing your vulnerability in the event of a resurgence of COVID-19.

Information about your vaccination status will be shared with your Manager.

Vulnerability Assessment

Health Conditions

The following health conditions have been linked with increased risk from COVID-19:

- Heart disease
- Lung disease
- Diabetes
- Cerebrovascular disease
- Conditions causing immunocompromised states
- Individuals on immunosuppressant medications, including long-term treatment with steroids/prednisolone
- Liver or kidney disease
- Cancer
- Pregnancy (over 28 weeks)

Do you have a medical condition listed above?	Yes/ No
Are you over the age of 70?	Yes/ No
Have you had a vulnerability assessment undertaken previously? • If you have selected yes: <ul style="list-style-type: none"> a) Do you know what your category status was? b) Do you believe your status has changed? 	Yes / No 1, 2, 3, 4 Yes / No
Have you been fully vaccinated against COVID-19? • If you have selected Y, what was the date of your second dose?	Yes / No ____/____/____
Have you been fit tested for an N95 mask? If you have selected Y: <ul style="list-style-type: none"> a) Did you pass or fail the fit testing? b) If you passed, could you please name the brand and size of N95 mask that you fit? 	Yes / No Pass / Fail -----

SECTION 4

Please ensure you have completed all sections of this form before signing the declaration.

I give my consent for the MidCentral DHB's Occupational Health Physician (or in that person's absence, MidCentral DHB appointed nominee) to coordinate the assessment of any health condition or disability which I have declared, and I understand that this may involve me being requested to undergo a medical examination.

I understand that this information is confidential to MidCentral DHB and will be subject to the provisions of the Privacy Act 1993 and the Health Information Privacy Code 1994.

I understand that withholding of information or providing incorrect information on this form could disqualify me as an applicant, or, if appointed, render me liable to dismissal.

I declare to the best of my knowledge and belief the information I have given above is correct.

Signature _____

Date _____