OCCUPATIONAL HEALTH RECORD

Reset Form

The information in this Occupational Health Record provides baseline information and indications to ensure the health and safety of health care workers and patients.

To be completed by applicant:

Legal Last Name: _____ **Legal First Name:** _____
Middle Name(s):_____**Preferred Name**: _____
Health Card # _____
Sex assigned at birth: ☐ **Female** ☐ **Male** **Birth Date** (DD/MM/YYYY): _____
Address: _____ **City/Town:** _____**Postal Code:**_____
Phone (H): _____ **(C):** _____ **E-mail:** _____
Job Title: _____ **Designation (FT, PT, Casual, Term):** _____
Department: _____ **Work Site:** _____

1. Have you been employed, volunteered or been a student with Nova Scotia Health in the past? ☐ Yes ☐ No

If yes, please name the facility or location: _____

If different from above, what was your name at that time? _____

2. Do you have any of the following? If yes, please explain:

Current and/or recurring (chronic) medical/health condition(s):
☐ Yes ☐ No _____

Current medication(s):
☐ Yes ☐ No _____

Any medical condition(s) that make you prone to infections:
☐ Yes ☐ No _____

Past surgery:
☐ Yes ☐ No _____

Past and/or present limitations that affect your ability to do any of the following activities:

Walking: ☐ Yes ☐ No Standing: ☐ Yes ☐ No

Sitting: ☐ Yes ☐ No Concentration: ☐ Yes ☐ No

Lifting: ☐ Yes ☐ No

If yes, please describe limitations:

_____

_____

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Past and/or present WCB claims:
☐ Yes ☐ No If yes, what was the date of your clearance for full duties and full hours? _____

If yes, do you have any current limitations or restrictions? Please describe:
_____

Vision problem(s) not corrected by glasses or contacts:
☐ Yes ☐ No _____

Hearing problem(s):
☐ Yes ☐ No _____

Skin condition(s):
☐ Yes ☐ No _____

If your skin condition is on your hands, does the use of hand soap/sanitizers/gloves make this condition worse? ☐ Yes ☐ No

3. Have you had any documented exposure to any of the following hazards without use of recommended Personal Protective Equipment (PPE) that caused an injury or illness? If yes, please explain:

Chemicals (e.g., lead, asbestos, solvents, hazardous drugs) ☐ Yes ☐ No
_____
Noise ☐ Yes ☐ No _____
Radiation ☐ Yes ☐ No _____

4. Do you have allergies and/or sensitivities? If yes, please explain:

Latex ☐ Yes ☐ No _____
Drugs ☐ Yes ☐ No _____
Chemicals ☐ Yes ☐ No _____
Insect stings ☐ Yes ☐ No _____
Fragrance ☐ Yes ☐ No _____
Other: _____
Any anaphylactic allergies: _____

I acknowledge that the Occupational Health Safety and Wellness (OHSW) team is collecting this information to assess if my health might impact my ability to perform essential job duties. This ensures my protection as well as the safety of patients, colleagues, and the organization as a whole. For this reason, I agree to disclose my relevant medical information so modifications can be made where possible. OHSW will maintain confidentiality of my personal health details but will share fitness for work information with my employer. I verify that the information I have provided is accurate and comprehensive to the best of my knowledge, considering the potential risks to both my personal health and the well-being of patients and colleagues.

Applicant Signature: _____ **Date:** _____
(DD/MM/YYYY)