

# OCCUPATIONAL HEALTH RECORD

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)