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| **PRE-PLACEMENT HEALTH QUESTIONNAIRE****FACT SHEET FOR APPLICANTS** |

**A GUIDE FOR APPLICANTS:**

To assist us to keep our employees safe YLO (Residential Care Services) undertakes a Pre-Placement Health assessment

process during its Recruitment & Selection process.

In October 2013, the Queensland Government amended the *Workers’ Compensation and Rehabilitation Act 2013* to require prospective employees, if requested in writing, to provide an employer with a notification of pre-existing injuries that would

be aggravated by performing the duties of the position applied for and, in particular circumstances, allow for access to prospective employee’s WorkCover claims history. Please refer

to the WorkSafe website for more information.

**WHAT YOU MUST DO:**

As part of the Pre-Placement Health assessment process you

will be asked to identify an pre-existing medical conditions or injuries which you suspect would be aggravated by performing the duties of the position you have applied for **(notifiable conditions)**. The duties for the position you have applied for are set out in the Position Description. If you do not have either document, please request one from Human Resources.

**IMPORTANT**

If you fail to disclose or knowingly provide false or misleading information about your *notifiable conditions*, WorkCover may not cover you for accidents which involve an aggravation of a notifiable condition or pre-existing injury.

A false or misleading disclosure during this process may also lead to the Termination of your Employment (or mean that an Offer of Employment is not made to you).

**HOW DO YOU KNOW IF A PRE-EXISTING INJURY OR CONDITION WOULD BE AGGRAVATED BY THE WORK DUTIES?**

To assist you to determine if the job you are applying for is suitable for you, you have been provided with a Position Description which is applicable to the role you have applied for.

**When completing the Questionnaire it is suggested:**

**Step 1** On a separate piece of paper, list all of the pre-existing medical conditions or injuries which have or have not been diagnosed or treated by a health professional.

You must destroy this list once you have completed Step 3 of this process. You will only be required to provide us with the completed Questionnaire.

**Step 2** Using the Position Description for the position you are applying for (provided) consider each pre-existing medical condition or injury in turn and ask yourself could this pre-existing medical condition or injury be aggravated by doing the duties of this position?

If you are unsure consider contacting your health care provider, e.g. your Doctor or Physiotherapist.

**Step 3** If any of your answers in **Step 2** are **Yes**, then you must disclose these pre-existing medical conditions or injuries in Section 1 of the Questionnaire.

**How will the information you have provided be used by YLO (Residential Care Services)?**

Only information relevant to your capacity to perform safely in the position you are applying for will be taken into account.

The information you provide will not be used for any purpose other than to assess your ability to perform the position you are applying for safely and to determine whether, if you are employed by YLO (Residential Care Services), any reasonable adjustments are required to accommodate any pre-existing medical condition or injury you have.

If you are not employed by YLO (Residential Care Services) the medical information will be securely destroyed 21 days after the close of the Recruitment & Selection process. If you are employed by YLO (Residential Care Services) the information that you provided will be kept securely on your Personnel File.

Information that you provide will only be released to other parties as required by law.

**Requests for Further Information**

YLO (Residential Care Services) may request further information from you as part of the Recruitment & Selection process which may include a request that you undergo a Pre-Employment Medical Screening.

**REMEMBER** to sign Sections 3 & 4 of the form.

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| **PRE-PLACEMENT HEALTH QUESTIONNAIRE** |

**APPLICANT DETAILS:**

|  |  |  |  |
| --- | --- | --- | --- |
| Title (please circle): Miss / Ms / Mrs / Mr / Dr | Given name:       | Surname: |       |
| Postal Address: |       |
|  |       |
| Telephone: | Home |  | Work |  | Mobile: |  |
| Email: |       |
| Date of Birth |       | M F |
| Position Applied for:  |       |

***Please carefully read the Position Description for the role (as provided). If you need more information, please ask Human Resources for clarification before signing this form.***

**SECTION 1: HEALTH DISCLOSURE**

|  |  |  |
| --- | --- | --- |
| **Health History** | **YES / NO****(please circle)** | **Describe** |
| Do you have any pre-existing injuries or medical conditions that you suspect would be aggravated by performing your employment related duties as set out in the Position Description for the role?**Pre-existing injuries and medical conditions** includes both physical and psychological conditions and injuries. **Note:** If you knowingly make a false or misleading disclosure in response to this question you will not be entitled to compensation or to seek damages for any event that aggravates the pre-existing injury or medical condition.  | YES / NO |  |
| Do you have, or have you ever had, any injuries or medical conditions which would impact on the safe performance of either the physical or psychological demand factors listed in the Position Description.  | YES / NO |  |
| Do you have any injuries, illnesses or conditions which would make it difficult to undertake any of the activities outlined in the Position Description? | YES / NO |  |
| Are you taking any medications that could impact on your ability to perform the duties of your employment & / or impact on your ability to safely operate either a Motor Vehicle or equipment used in the position you have applied for? | YES / NO |  |
| Have you been immunised against Tetanus, Hepatitis A & / or Hepatitis B | YES / NO |  |

**SECTION 2: WORKER’S COMPENSATION CLAIMS HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Approximate Year** | **Injury / Illness** | **Period/s off Work** | **Ongoing Issues****(please circle)** |
|  |  |  | YES / NO |
|  |  |  | YES / NO |
|  |  |  | YES / NO |
|  |  |  | YES / NO |
|  |  |  | YES / NO |
|  |  |  | YES / NO |
|  |  |  | YES / NO |
|  |  |  | YES / NO |

**SECTION 3: APPLICANT DECLARATION** (must be completed by the Applicant)

***Do you acknowledge that you are capable of meeting the physical and psychological requirements and working conditions of the position you are applying for?***

|  |
| --- |
| YES / NO |

I hereby certify that I have read and understood the Position Description provided outlining the duties and the physical and psychological requirements of the position I have applied for, and understood the above questions and confirm that the answers given above are correct, to the best of my knowledge. I understand that if any information in this questionnaire is knowingly false or misleading, my application may not be considered & / or my employment may be terminated. I understand that if I do not disclose the existence of any pre-existing injury or medical condition that I suspect, or ought reasonably suspect, would be aggravated by performing the duties of the position I have applied for, that I may not be entitled to Workers’ Compensation or to seek damages for any event that aggravates the pre-existing injury or medical condition.

**Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION 4: CONSENT TO RELEASE OF INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of the above stated address, consent to the release of the results of my Pre-Placement Health Questionnaire and any additional medical information I have provided to YLO (Residential Care Services) in connection with medical conditions and injuries I have disclosed herein to YLO (Residential Care Services) and relevant medical and allied health personnel.

**Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_