**OCCUPATIONAL HEALTH DEPARTMENT**

**PRE INDUCTION QUESTIONNAIRE FOR VOLUNTEER POSTS**

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| FULL NAME: ………………………………………………DOB ……………………………………  HOME ADDRESS: …………………………………………………………………………………....  Telephone number . ……………………… Mobile number ……………………..……………  Volunteer post …………………….…………………………….………………………………….…  Based at WORC / KIDD / ALEX (please circle correct response)  **DETAILS OF VOLUNTEER POST (Volunteer coordinator to complete)**  How many hours of voluntary activity do you plan to do each week? . ………………………………….…..  How many hours maximum do you expect to do in one period? …………………………….….  What volunteer activities are involved in your role? Please describe………………………….…….………..  ……………………………………………………………………………………..……………….……………….  What area/ward/department is your voluntary work based in? …………………………………….………...  What contact will you have with patients (eg: social interaction / food preparation / direct touching contact)? ……………………………….………..……………………………………………………………. | | |
| **HEALTH QUESTIONNAIRE, TO BE COMPLETED BY THE VOLUNTEER** The purpose of this questionnaire assessment is to identify any health problems or disabilities that may make the proposed volunteer post difficult or unsafe for you or others, and to enable WAHT to identify any adjustments that may be required. **GUIDANCE.**  The types of health problems that can affect volunteers may include (this list is not exhaustive);  **1**.Problems with standing, bending , walking and lifting, due to current muscle or joint problem if the work requires physically demanding activities, or moving and handling equipment. **2.**Some medications, if they cause side effects such as drowsiness, or immunosuppression.  **3.**Mental health conditions such as, Bi Polar Disorder and other mental health diagnosis, anxiety or depression, or drug/alcohol misuse. **4**.Conditions that may cause sudden loss of consciousness eg epilepsy or insulin dependent diabetes **None of these will necessarily prevent you from volunteering but we need to know about them for your safety and for that of our patients** | | |
| Do you have any health issues that may affect your ability to undertake the duties of your volunteer post, and may require adjustments or changes to be made?.  Please provide details; ……………………………………………………………………………………………  …………………………………………………………………………………………… | Yes | No |
| Are you having, or waiting for treatment (including medication) or investigations at present that might affect your ability to perform your volunteer post?  Please provide details.  ……………………………………………………………………………………………  …………………………………………………………………………………………… | Yes | No |

Signature of volunteer ……………………………………………………………. Date ……………………………

**ALL VOLUNTEERS** Please send in details of any vaccinations you may have had. Please obtain this from your GP. We would like to know if you are immune to Measles and Rubella and if you have had Chicken pox if you are working with children or babies. Occupational Health can provide immunisation if you are not covered.

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| **For use by OCCUPATIONAL HEALTH** |
| Fit YES / NO Unfit YES / NO  Fit with restrictions YES / NO Signature ………………………………….…. Date ……………….. |
| This form should be returned to:  **Occupational Health & Wellbeing Services, Working Well Centre, Newtown Road, Worcs WR5 1JF** |