Pre-placement Health Checklist

MSS Group of Companies takes its responsibility for duty of care seriously. This duty of care requires an understanding of what risks prospective employees might carry in order to manage the risks and avoid illness and injury in the working environment. The pre-placement health checklist may be used for a variety of purposes including pre-employment, pre-placement, health monitoring, or permanent appointment. The checklist assists MSS to ensure that the prospective employee is fit to work in a specific environment and can fulfil the inherent requirements of the role.

Given Name		**Surname**	
Date of Birth			
Position Applied For			

	Question	Y	N
1	**Do you smoke or have you smoked in the past?** *If yes, what period and how many cigarettes per day?* *How long can you abstain from smoking?*	☐	☐
2	**Do you drink alcohol?** *If yes, how many standard drinks per day?*	☐	☐
3	**Are you currently taking any medications prescribed by a doctor?** *Excluding the contraceptive pill* *If yes, what medication are you currently taking?*	☐	☐
4	**Some roles require the use of a chair and therefore we need to ensure we have an appropriately rated chair to ensure a safe working environment. For this purpose, please list your weight:**		

	Question	Y	N
	Do you or have you ever had any of the following:		
5	High blood pressure?	☐	☐
6	Heart disease or condition e.g. heart surgery?	☐	☐
7	Diabetes?	☐	☐
8	Shortness of breath, chest pain or exertion?	☐	☐
9	Lung problems e.g. asthma, bronchitis?	☐	☐
10	Liver, kidney or bladder disease?	☐	☐
11	Blood disease e.g. anaemia, leukemia?	☐	☐
12	Skin cancer?	☐	☐
13	Epilepsy or fits?	☐	☐
14	Dizziness, faints, turns or blackouts?	☐	☐
15	Migraine or frequent headaches?	☐	☐
16	Stomach or duodenal ulcers, frequent indigestion?	☐	☐
17	Abdominal or bowel disorder?	☐	☐
18	Hernia, rupture or prolapse of any kind?	☐	☐
19	Hearing loss or deafness or ringing in the ears?	☐	☐
	If yes, do you wear a hearing aid?	☐	☐
	If yes, when was the last time you had a hearing assessment?		
20	Issues with your vision?	☐	☐
	If yes, do you wear glasses / contact lenses?	☐	☐
21	Nervous or mental condition?	☐	☐
22	Anxiety, abnormal stress reaction or depression?	☐	☐
	If yes, have you taken any time off work?	☐	☐
	If yes, was / is your condition made worse by work?	☐	☐
	If yes, are you taking any medication?	☐	☐
	If yes, are you receiving specialist care?	☐	☐
23	Issues with sleeping or been diagnosed with sleep apnoea?	☐	☐
24	Joint pain or arthritis?	☐	☐
25	Do you have any prosthetic limbs?	☐	☐
26	Have you required any joint replacements or joint reconstruction e.g. hip, knee, shoulder?	☐	☐
27	Allergies? *If yes, what allergies?*	☐	☐
28	Any significant infectious illness e.g. hepatitis?	☐	☐
29	Prolonged periods of time off work for illness in the last three years?	☐	☐
30	Any other health complaints?	☐	☐
31	Are you currently being treated for any ailments listed about?	☐	☐
32	Are you allergic to anything e.g. food, chemicals, insects?	☐	☐
33	Do you require any other aids e.g. walking aid?	☐	☐
34	Do you require or have you ever had major surgery?	☐	☐

Do you have, or have you ever (at any time) suffered from the following?								
Injury	**Y**	**N**	**Injury**	**Y**	**N**	**Injury**	**Y**	**N**
Head Pain / Injury	☐	☐	Back Pain / Injury	☐	☐	Ankle Pain / Injury	☐	☐
Neck Pain / Injury	☐	☐	Hip Pain / Injury	☐	☐	Upper or Lower Leg Pain / Injury	☐	☐
Arm / Shoulder Pain / Injury	☐	☐	Knee Pain / Injury	☐	☐	Foot Pain / Injury	☐	☐

Question *(If you answered yes to any of the above then please complete this section)*		**Y**	**N**
35	Was the pain / injury caused by work?	☐	☐
36	Is or was the pain / injury made worse by work?	☐	☐
37	Did you have to change your job or duties due to the pain / injury?	☐	☐
38	Has the pain / injury fully recovered?	☐	☐
39	Is the injury degenerative?	☐	☐
40	Do you have any ongoing problems due to the injury?	☐	☐
41	Have you had any operations due to the injury?	☐	☐

Question		**Y**	**N**
42	**Have you ever had any work-related injury or illness?**	☐	☐
43	Please specify injury/illness and part of body affected		
44	Employer(s) Name		
45	Date of Injury(ies)		
46	Were you considered unfit for duty following the injury / illness? If so, for what period?	☐	☐
47	Were you placed on modified duties following the injury / illness? If so, for what period?	☐	☐
48	Were you certified fit for your normal role? *If so, what date were you cleared*	☐	☐
49	Are you receiving ongoing treatment for the injury / illness?	☐	☐
50	Are there any limitations to your current physical ability due to the injury / illness?	☐	☐

Question		**Y**	**N**
51	**Have you ever worked with any substance or in any conditions which may have been hazardous to your health? (E.g. asbestos exposure, toxic chemicals, noisy environment)**	☐	☐
52	Please specify the exposure(s)		
53	Employer name(s)		
54	Date(s) of exposure		

Do you have difficulty with any of the following?					
Task	**Y**	**N**	**Task**	**Y**	**N**
Crouching, bending or kneeling	☐	☐	Shift work or sleep issues	☐	☐
Lifting heavy weights in excess of 16 kilo's	☐	☐	Working in hot / cold temperatures	☐	☐
Repetitive movements	☐	☐	Working at heights	☐	☐
Working above shoulder height	☐	☐	Confined spaces	☐	☐
Sensitivity to loud noises	☐	☐	Sensitivity to bright lights	☐	☐
Walking on uneven ground	☐	☐			

Do you have difficulty walking down stairs? ☐ ☐

If you answered yes, please indicate what your daily limit is before you have difficulty?

Flights of stairs: 10 ------ 20 ------ 30 ------ 40 ------ 50 ------ 60 ------ 70 ------ 80 ------ 90 ------ 100

Do you have difficulty walking up stairs? ☐ ☐

If you answered yes, please indicate what your daily limit is before you have difficulty?

Flights of stairs: 10 ------ 20 ------ 30 ------ 40 ------ 50 ------ 60 ------ 70 ------ 80 ------ 90 ------ 100

Do you have difficulty walking long distances up to 30km a day? ☐ ☐

If you answered yes, please indicate what your daily limit is before you have difficulty?

Distance (km): 1 ------ 2 ------ 3 ------ 5 ------ 7 ------ 10 ------ 15 ------ 20 ------ 25 ------ 30

Do you have difficulty sitting for an extended period up to 12 hours? ☐ ☐

If you answered yes, please indicate what your daily limit is before you have difficulty?

Hours: 1 ------ 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------ 10 ------ 11 ------ 12

Do you have difficulty standing for an extended period up to 12 hours? ☐ ☐

If you answered yes, please indicate what your daily limit is before you have difficulty?

Hours: 1 ------ 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------ 10 ------ 11 ------ 12

Have you been immunised for the following?							
Immunisation	**Y**	**N**	**Date**	**Immunisation**	**Y**	**N**	**Date**
Hepatitis A/B (Twinrix)				Mumps			
Hepatitis A				Rubella			
Hepatitis B				Varicella			
COVID-19 1st Dose				Pertussis			
COVID-19 2nd Dose				Measles			
Tetanus							

Note: *New employees commencing in nominated positions with MSS Security are required to provide evidence of immunisation for Hepatitis A, Hepatitis B and/or Tetanus. If no evidence is available serology testing, or vaccinations may be required.*

Applicant Declaration *(must be completed by the applicant)*
Do you believe 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 the information sheet included within this Pre-placement Health Checklist and understand the purpose and uses for the checklist. I declare that the information I have provided on this form is, to the best of my knowledge, true and complete and no information concerning my past or present state of health has been withheld. I understand that if any information in this checklist is knowingly false or misleading, my application may not be considered and 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 this role, that I will not be entitled to workers' compensation or to seek damages for any event that aggravates the pre-existing injury or medical condition.

I consent to the release of my Pre-placement Health Checklist and any additional medical information I have provided to MSS in connection with medical conditions I have disclosed therein to the organisation's authorised personnel and relevant medical and allied health personnel.

Employee Name	
Signature	
Date	

If you responded **YES** to any of the above questions, please provide further details below *(excluding 'Have you been immunised for the following'):*

Question:	
Details:	
Question:	
Details:	
Question:	
Details:	
Question:	
Details:	
Question:	
Details:	
Question:	
Details:	