

HEALTH SERVICE EXECUTIVE
PRE-PLACEMENT HEALTH ASSESSMENT FORM
CONFIDENTIAL TO OCCUPATIONAL HEALTH DEPARTMENT
This form is available in larger font upon request

Sections 1-2 to be completed by Manager

Section 1: Details of post (this section to be completed by Manager):

Post/Grade: Staff Nurse	Department/Location: Galway University Hospitals
Hours of Work: 37.5 hours per weeks	Start Date: ASAP
Name of HR Officer: Veronica Higgins	HR Contact Details: Email: veronicam.higgins@hse.ie
Recruitment Area: HSE West and North West Region	Recruitment Officer: Colette Murray
Name of Manager: Ms. Marie Burns	Manager's Contact Details: Email: marie.burns@hse.ie
Occupational Fit Slip to be Returned by Occupational Health Unit to:	HR Department/Recruitment Service: Email: Resources.Human@hse.ie

Section 2: Required duties and job description
(attach a copy of the current job description and person specification)

Includes (tick all that apply): <input type="checkbox"/> Driving <input type="checkbox"/> Working at height <input checked="" type="checkbox"/> Regular VDU work <input checked="" type="checkbox"/> Night working <input type="checkbox"/> Food handling <input type="checkbox"/> Working with Ionising radiation <input type="checkbox"/> Other (please specify):	Exposure to (tick all that apply): <input type="checkbox"/> Noise (>80dBA) <input type="checkbox"/> Cytotoxic drugs <input type="checkbox"/> Respiratory sensitisers <input type="checkbox"/> Vibrating equipment <input type="checkbox"/> Other (please specify):	Consists of (tick all that apply): <input checked="" type="checkbox"/> Contact with patients <input checked="" type="checkbox"/> Patient moving and handling <input checked="" type="checkbox"/> Inanimate moving and handling <input type="checkbox"/> Invasive surgical or Exposure Prone Procedures (EPP) <input type="checkbox"/> Work in confined spaces <input type="checkbox"/> Other (please specify):
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Assessment of Post in line with HSE HR Circular 19/2008
Exposure Prone Procedure (EPP) Post

HSE HR Circular 19/2008 defines Exposure Prone Procedures (EPPs) as 'those invasive procedures where there is a risk that injury to the health care worker may result in the exposure of the patient's open tissues to the blood of the health care worker. These include procedures where the health care worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (e.g. spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times'

Effective July 2008 all staff hired, transferred or promoted into an EPP post will be required to provide evidence via Occupational Health service of their freedom from infection in line with Circular 19/2008. No appointment will be made in the absence of such evidence.

A full copy of Circular 19/2008 and detailed information on those categories of staff and procedures coming under the scope of the EPP definition is available from the Area Recruitment Unit.

If there is any doubt about whether the post you have identified above comes within the definition of an EPP post, expert advice should be sought from the Occupational Health Service:

Does the post above identified for filling come within the definition of an
Exposure Prone Procedure (EPP) Post?(Tick below as appropriate)

Please refer to HSE HR Circular 012/2009 Implementation of Recommendations of Report on The Prevention of Transmission of Blood Borne Diseases in the Health Care Setting (appendix 1 Definitions) before completing this section

YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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**HEALTH SERVICE EXECUTIVE
PRE-PLACEMENT HEALTH ASSESSMENT FORM
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Job Title: Staff Nurse	Location: GUH
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Sections 1a-8 to be completed by prospective employee and returned to:

OCCUPATIONAL.HEALTHUHG@HSE.IE

Section 1a: Information for prospective employees regarding confidentiality

All information on this form will be treated as strictly confidential at all times, in accordance with the provisions of the General Data Protection Regulations (GDPR) along with the Data Protection Acts (1988 & 2003). No personal or medical information will be disclosed to a third party on an individual identifiable basis without your consent. The purpose of the pre-placement health assessment is:

- To determine the prospective employee's fitness to carry out the duties of the post and to assist the HSE in meeting its obligations under the Safety, Health & Welfare at Work Act 2005
- To ensure the HSE complies with the Employment Equality Acts (1998 & 2015) by advising on measures that may be required to enable the prospective employee to carry out the duties of the post and render regular and efficient service
- To form the basis of a confidential occupational health record. This occupational health record will be held separately from other employment records maintained by the HSE.

A recommendation regarding your medical fitness for duty will be issued to Human Resources.

Section 2a: Personal details

Family Name: RAVARIKANDY	Family name at birth (if different):
First names: ADITHYA	Date of birth: 09/01/1998
Gender: FEMALE	
Address: 11 HILLCREST, CAPPAGH, KINSALE CO. CORK. P17D621	GP Name and address: Dr. PADRIAC MCCARTHY, KINSALE MEDICAL, KINSALE, CO. CORK
Telephone number: 085 884 7244	GP telephone number: 021 477 2253
Email: adithyasairk@gmail.com	GP email:

Section 3: Present and previous employment, including HSE employment

Please provide details of your previous three posts, starting with your present or most recent post

Job title	Employer name and address	From	To
STAFF NURSE	KINSALE COMMUNITY HOSPITAL, KINSALE, CO. CORK. KERRY	07/12/2023	Full Date
STAFF NURSE	NEW JANAPRIYA SUPER SPECIALITY HOSPITAL, #2M-3A EAST OF NGEF Layout, KASTHURBANAGAR PIN-560043	01/05/2022	31/06/2023
STAFF NURSE	FATHER MULLER MEDICAL COLLEGE HOSPITAL, KANKANADY, MANGALURU -PIN- 575002	09/03/2020	30/04/2023

Name: ADITHYAN RAVARIKANDY DOB: 09/01/1998

Section 5: Immunity and immunisation status

Clerical or administrative staff who do not have patient contact or contact with laboratory samples are not required to complete this section.

Healthcare workers with patient contact are required to provide information relating to their immunity to:

- TB
- Measles
- Mumps
- Rubella
- Varicella
- Hepatitis B (Anti-HBs)
- Covid-19

You must forward a completed immunisation/vaccination certificate from your current Occupational Health Department and copies of previous laboratory test results if available. Failure to provide this information may lead to a delay in health assessment that could affect your start date. If you do not have a current Occupational Health Department you must attend your new Occupational Health Department before commencing your new post. If you have never worked in the HSE your new Occupational Health Department will undertake this screening at your pre-placement health assessment.

Have you enclosed your immunisation/vaccination records?

☒ Yes

☐ No

State reasons why: _____

Healthcare workers with patient contact who may be involved in Exposure Prone Procedures (EPP) are required to submit evidence of non-infectivity to hepatitis B and C. Please provide a copy of your EPP certificate including the following information:

- Hepatitis B core antibody (Anti-HBc)
- Hepatitis B surface antigen (HBsAg)
- Hepatitis C antibody

These tests must be carried out on identity validated samples (IVS). Only results from an Irish or UK Occupational Health Service that has confirmed the identity of the person by checking appropriate photographic ID, e.g. passport or driving licence, will be accepted. For International recruitment, please refer to International recruitment documentation. Your consultant or manager will be advised that you cannot undertake EPP until all the requisite information has been received. If you are aware that you have any infectious disease or other health related condition that may impact upon your work, you have a responsibility to discuss this with the Occupational Health Professional.

Name: ADITHYA RAVARICANDYDOB: 09/01/1998**Section 6: Health and ability declaration**

Have you suffered from tuberculosis (TB)*

☐ Yes ☒ No

• Within the past 12 months:

- ☐ Has a family member or close contact has been treated for TB
- ☐ Have you had a cough for more than three weeks
- ☐ Have you coughed up blood
- ☐ Have you suffered unexplained weight loss
- ☐ Have you suffered from night sweats or fever
- ☐ Have you lived/visited in any country for more than 28 days within the last two years*
(name of country and duration of visit _____)

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

* This information is required to determine appropriate screening and management of those who have spent time in countries with a high incidence of TB (40/100,000 cases notified per year).
HPSC Guidelines on the Prevention and Control of Tuberculosis in Ireland 2010 (Amended 2014).

Please tick one of the following options:

☒ I am not aware of any health condition or disability that might affect my ability to undertake effectively the duties of the position that I have been offered.

☐ I do have a health condition or disability that might affect my ability to undertake effectively the duties of the position that I have been offered, and that might require special adjustments to my work or my place of work.

☐**(Please answer the questions below)**

- ☐ Have you had a medical condition or operation in the past five years
- ☐ Are you receiving treatment (including tablets and injections but excluding oral contraceptives or HRT) *include self-medication, physiotherapy, chiropractic treatment, psychological counselling or other support*
- ☐ Have you suffered a work-related illness or injury, or given up work due to ill health
- ☐ Do you have an impairment/disability (including intellectual disability) (including visual impairment, hearing impairment, dyslexia, dyspraxia etc)
- ☐ Have you suffered back, neck, joint or muscle problems
- ☐ Have you suffered from skin problems or allergies
- ☐ Do you suffer from an immune disorder or significant health condition or treatment that increases your vulnerability to infection
- ☐ Have you suffered from a mental disorder (including depression, anxiety, self-harm, eating disorder, psychological or emotional problems)
- ☐ Have you had a drug or alcohol abuse problem or other addiction

<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

If you ticked any of the boxes above please advise:

- When and for how long you had the problem
- What type of treatment you received
- Whether you were admitted to hospital, unable to work or prevented from carrying out your normal activities because of the problem
- Whether the condition affects you now in any way:

Name: ABITHYA RAUARIKANDY DOB: 09/01/1998

Section 7: Declaration by applicant

Please read the declaration below carefully

I declare that the information I have given is true and complete to the best of my knowledge and that I have not withheld any material facts. I understand that I am responsible for the accuracy of my statement. I understand, accept and confirm the entitlement of the Health Service Executive to reject my application or terminate my employment (in the event of a contract of employment having been entered into) where I have omitted to furnish any information relevant to this health assessment or where I have made any false statement or misrepresentation relevant to this health assessment.

I understand that the medical information given by me is confidential to the Occupational Health service and will not be disclosed to any other person without my explicit consent. A report on my fitness for the position offered will be given to management along with any recommendation for work adjustments that may be appropriate.

I understand that I may be required to undergo an assessment by Occupational Health if considered necessary. I agree to a relevant Occupational Health record being kept for the duration of my employment. I accept that I have an ethical and professional obligation to inform the Occupational Health Service, in confidence, if I am HIV positive/hepatitis B positive/hepatitis C positive in accordance with Department of Health guidelines.

Signed:  Date: 15/09/2025

Section 8: Occupational Health use only

Screened by:	Date:
OHP/OHA:	Result:
Comments	
Fit Slip to be returned to:	Resources.Human@hse.ie