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| **STRICTLY CONFIDENTIAL**  **VULNERABILITY QUESTIONNAIRE** | | | | | | | | |
|  | | |  |  | | |  | |
| The first section of the questionnaire should be completed by the staff member. It should be returned to your line Manager for completion of Section 2, and potential onward referral to Occupational Health via your HR Officer. | | | | | | | | |
|  | | | | | | | | |
| **Privacy Notice**  You are asked to complete this form in order to provide a medical view of your fitness for employment or specific task. Without this information your application/assessment of fitness will not be able to proceed further. The Occupational Health Practitioner may require further information about your health before being able to come to a view on your fitness. Your consent to further reports from your medical advisers will be sought in these circumstances before a certificate of fitness/restrictions/unfitness can be issued. All such medical information will be kept in strict medical confidence by the Occupational Health Practitioner. Your consent will be sought for any other use of all or part of this confidential medical data.  The University’s Staff Data Privacy Notice can be found here: <https://www.bangor.ac.uk/humanresources/Staff%20Privacy%20Notice.pdf>  You or your authorised representative may apply for access to your own occupational health records under the Data Protection Act 2018 by applying in writing to the University Data Protection Officer, gwenan.hine@bangor.ac.uk / extension 2413. | | | | | | | | |
|  | | | | | | | | |
| **SECTION 1 - For completion by the Employee:** | | | | | | | | |
| Employee Name | | |  | | | | | |
| Date of Birth | | |  | | | | | |
| Email Address or Home Address: | | |  | | | | | |
| Department | | |  | | | | | |
| Job Title | | |  | | | | | |
| Contact Number | | |  | | | | | |
| Are you over the age of 70? | | | Yes / No | | | | | |
| Are you pregnant? | | | Yes / No | | | | | |
| Do you have any underlying health condition(s)?: | | | | | | | | |
|  | chronic (long-term) mild to moderate respiratory diseases, such as asthma, chronic obstructive pulmonary disease (COPD), emphysema or bronchitis | | | | | | | Yes / No |
|  | chronic heart disease, such as heart failure | | | | | | | Yes / No |
|  | chronic kidney disease | | | | | | | Yes / No |
|  | chronic liver disease, such as hepatitis | | | | | | | Yes / No |
|  | chronic neurological conditions, such as Parkinson’s disease, motor neurone disease, multiple sclerosis (MS), or cerebral palsy | | | | | | | Yes / No |
|  | diabetes | | | | | | | Yes / No |
|  | a weakened immune system as the result of certain conditions, treatments like chemotherapy, or medicines such as steroid tablets | | | | | | | Yes / No |
|  | being seriously overweight with a body mass index (BMI) of 40 or above | | | | | | | Yes / No |
|  | I have an underlying health condition which encompasses the above categories but prefer not to disclose on this form | | | | | | | Yes / No |
|  | | | | | | | | |
| Employee Declaration  I declare that I have completed this form to the best of my knowledge and belief and that I have answered the relevant questions as accurately as possible. | | | | | | | | |
| Employee Signature | |  | | | Date |  | | |

\*\*PLEASE RETURN THIS FORM TO YOUR MANAGER UPON COMPLETION\*\*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
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| **SECTION 2 - For completion by the relevant Manager:** | | | | | |
| Completed by | |  | | | |
| Contact Number | |  | | | |
| Job Title | |  | | | |
| Email address | |  | | | |
|  | | | | | |
| Is the employee absent from work? | | Yes / No | | | |
| If yes, first date of absence: | |  | | | |
|  | | | | | |
| The employee is required to undertake significant physical work as part of their role | | | | | Yes / No |
| The employee is required to undertake a customer facing role | | | | | Yes / No |
| The employee is required work in various building locations on campus | | | | | Yes / No |
| The employee can maintain social distancing (2 metres) if returning to the workplace in their standard duties/following adjustments | | | | | Yes / No |
| The employee can complete their work at home | | | | | Yes / No |
|  | | | | | |
| Signed |  | | Date |  | |

\*\*PLEASE RETURN THIS FORM TO YOUR HR OFFICER WHO WILL THEN FORWARD TO OCCUPATIONAL HEALTH\*\*