WHS Questionnaire

As an employee of Spring Professional, our foremost concern is your health and safety. This questionnaire is designed to assist us in ensuring that our employees are only placed in assignments which they are capable of performing efficiently and safely and that no person is placed in an environment or given tasks that would likely result in physical or mental harm.

Please read this document carefully and discuss any queries that you may have prior to completing the form with your respective Spring Professional Consultant.

Full Name:	
Contact Telephone Number:	
Address:	
Family Doctor Details:	

IMPORTANT: The information obtained in this questionnaire will be treated in strict confidence and will only be used in conjunction with the requirements of a client assignment.

Injury Declaration

You are required to disclose to Spring Professional; any or all existing or pre-existing injuries, illnesses or diseases suffered by you which could prevent you from performing the duties associated with the employment for which you are applying with Spring Professional; or be accelerated, aggravated, exacerbated, deteriorate or recur by you performing the duties associated with the employment for which you are applying with Spring Professional.

As per relevant legislation, if you fail to disclose this information or if you knowingly provide false or misleading information in relation to any pre-existing injury/condition you and your dependents may not be entitled to any form of workers' compensation or to seek damages for any event that aggravates the pre-existing injury or medical condition and this may also constitute grounds for disciplinary action or dismissal.

SECTION A: HEALTH HISTORY

Please mark ☑ in the appropriate boxes:

1. Have you ever been medically retired on the grounds of ill health? YES ☐ NO ☐

If YES, please provide details of the illness, injury or medical condition

2. Do you have a physical or psychological condition that might prevent you from some work duties or certain workplace environments (e.g. asthma, vertigo)? YES ☐ NO ☐

If **YES**, what is the nature of the condition?

3. Do you suffer from any allergies? YES ☐ NO ☐

If **YES**, please list ALL allergies (for example: Dust, Nuts, pollens).

4. Some work duties and workplace environments may not be advisable for pregnant women. If you wish to indicate that you are pregnant you may do so voluntarily here? YES ☐ NO ☐

5. Have you had regular exposure to the following hazards in your past workplaces/jobs?

	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Loud noise/ explosives/gun fire	☐	☐	Asbestos	☐	☐	Toxic or hazardous chemicals	☐	☐
Radiation	☐	☐	Dust	☐	☐			

6. Please tick any injuries or conditions in the following list that you have ever experienced any difficulty with. It is **COMPULSORY** that you complete this information.

	Yes	No		Yes	No		Yes	No
Any neck or shoulder injuries/pain	☐	☐	Any back injury/pain e.g. Scoliosis	☐	☐	Any arm, hand, elbow or wrist injury/pain	☐	☐
Any knee, leg or ankle pain/injury	☐	☐	Any operations or surgery	☐	☐	Head Injury	☐	☐
Repetitive strain or overuse injury	☐	☐	Any stomach strain/hernias	☐	☐	Epilepsy, fits, seizures, blackouts	☐	☐
Skin disorders, dermatitis, eczema	☐	☐	High/Low blood pressure	☐	☐	Loss of hearing, Impaired Hearing*	☐	☐
Difficulty with vision or sight in either eye, Impaired Vision*	☐	☐	Persistent or frequent headaches, migraines	☐	☐	Dizziness, fainting, vertigo	☐	☐
Asthma or other respiratory/breathing problems	☐	☐	Arthritis, rheumatism	☐	☐	Heart trouble, angina	☐	☐
Any problems with bones/joints or muscles	☐	☐	Speech impairment	☐	☐	Stomach problems, ulcers	☐	☐
Infectious disease	☐	☐	Stress/Anxiety or nervous disorder	☐	☐	Fatigue/tiredness related issues	☐	☐

If you have indicated **YES** to any listed above please provide further dates and details.

* If you indicated YES to Impaired Hearing or Impaired Vision, when did you last have your hearing and/or eyesight (please circle as appropriate) tested?

Date:	
Test results:	

7. Have you ever worked with any substances or in any conditions as listed above for which you need a modified workplace? YES ☐ NO ☐

If yes, what specific adjustments or modifications can be made (if any) to ensure your workplace is safe and without further risk to your health?

SECTION B: MEDICAL DETAILS

1. Are you currently receiving any medical treatment for illness, injury or medical condition?
   YES ☐ NO ☐

If YES, please provide details of the illness, injury or medical condition

2. Are you taking any medication that has the potential to cause drowsiness or affect your work performance (including operating machinery? YES ☐ NO ☐

If YES, please provide details

3. Do you have any pre-existing and/or chronic and/or long term injuries or illness? YES ☐ NO ☐

If YES, please provide details

4. In the last 5 years, have you worked in an environment where hearing tests were regularly conducted? YES ☐ NO ☐

If YES, please provide details and a copy of your most recent hearing test results:

5. Have you ever had a work-related injury? YES ☐ NO ☐
   Was a Work Cover Claim made? YES ☐ NO ☐

If YES, please provide details of injury, workplace and approximate date of injury/ies:

SECTION C: PHYSICAL ABILITIES

1. Please indicate whether you have, or could have, difficulties performing any of the following activities.

	Yes	No		Yes	No		Yes	No
Crouching/bending /Kneeling (repeatedly)	☐	☐	Standing for 30 minutes	☐	☐	Sitting for up to 30 minutes	☐	☐
Hearing a normal conversation	☐	☐	Lifting objects weighing 15 kilograms or more	☐	☐	Working above shoulder height	☐	☐
Gripping objects firmly with both hands	☐	☐	Repetitive movement of hands or arms	☐	☐	Climbing a ladder/working at heights	☐	☐
Walking up and down stairs	☐	☐	Walking/working on uneven ground	☐	☐	Using hand tools/operating machinery	☐	☐
Working in hot/cold environments inc. refrigerated storage.	☐	☐	Wearing personal protective equipment (PPE)	☐	☐	Handling meat and/or food produce	☐	☐
Performing Shift Work	☐	☐	Working at heights	☐	☐	Working in confined spaces or underground	☐	☐

If you have indicated **Yes** in the above, then please provide further details of the nature of the difficulty/ies:

I declare that the information I have given on this form is complete and correct. I understand that any false or misleading information may result in termination of employment

Associate Name	**Signature**	**Date**

Spring Professional Representative Name	**Signature**	**Date**