



HEALTH REVIEW—EMPLOYEE QUESTIONNAIRE

(Must be provided to the Occupational Health & Safety (OHS) Department no later than 12:00pm (noon) on the Thursday prior to your start)

A. IDENTIFICATION

Last Name:	First Name:
Address:	Tel: (Home)
	Tel: (Department)
Job Title:	Department: Manager:

B. PERSONAL MEDICAL HISTORY

The following questions are important to identify any health conditions that could be affected by potential exposure to workplace hazards.

Have you ever received medical treatment for the following:

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Back/neck injury or pain	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/HIV
<input type="checkbox"/>	<input type="checkbox"/>	Upper limb (shoulder, elbow, wrist, hand) injury or pain	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems
<input type="checkbox"/>	<input type="checkbox"/>	Lower limb (hip, knee, lower leg, ankle, foot) injury or pain	<input type="checkbox"/>	<input type="checkbox"/>	Immunosuppression
<input type="checkbox"/>	<input type="checkbox"/>	Visual problems	<input type="checkbox"/>	<input type="checkbox"/>	Latex allergy or other skin sensitivities
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	MRSA/VRE
<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Loss of consciousness			

Have you ever had a work-related injury or illness? Yes No **If yes, please describe:**

Do you require accommodation to complete your essential job duties now? Yes No **If yes, please describe:**

Do you have restrictions that require accommodation related to your personal safety in the event of an emergency evacuation? Yes No **If yes, please describe:**

Do you have any skin conditions on your hands (symptoms like redness, open areas, cracks, dryness, itchy, burning, soreness) that may impact your ability to follow proper hand hygiene requirements?

Yes No **If yes, please describe:**

C. AUTHORIZATION

I hereby declare that this information is true and complete. I understand that all medical information provided by me will be kept confidential as per the Sinai Health (SH) Confidentiality of Employee Information Policy. Should I have any need for accommodation due to an existing disability, the SH Accommodation Policy and Disability Management Procedures will be followed.

EMPLOYEE SIGNATURE: _____

DATE: _____

Sinai Health is committed to protecting your privacy. The personal information collected in this form is collected in accordance with the Occupational Health and Safety Act and the Workplace Safety and Insurance Act. It will be used and maintained by the institution for the intended purpose of providing you with Occupational Health & Safety services. If you have any questions about the collection, use and disclosure of the personal information provided on this form, please email the OHS Department at obs.bh@sinaihealth.ca or call 416-461-8252 ext. 2802.