

## (HHAQ)

**Department Name:** \_\_\_\_\_

**Position Title:** \_\_\_\_\_

**Position Number (Staff or Post Graduate Student Number If applicable):** \_\_\_\_\_

**Staff (or Student) Number:** \_\_\_\_\_

The HHAQ is designed to assess the potential hazards of a particular job for a particular employee. In order to assess those risks, the HHAQ must be completed and lodged with the Occupational Health Nurse before the prospective employee commences employment. All material collected on the HHAQ and in any further medical examination remains confidential and filed in the office of the Occupational Health Nurse.

This form is to be used in conjunction with Personnel, Policy and Procedures Manual section 3.2 <http://www.unimelb.edu.au/ppp/docs/3.html#3.2>. The Head of Department must ensure **Parts A, B and C** of this form are filled in completely before signing the form. Partially completed forms may be sent back to departments for completion before an assessment is conducted.

### CONFIDENTIALITY

Information on Part D of this form will remain strictly confidential and remain the property of the Occupational Health Service of the University of Melbourne.

### Part A – Personal Details (to be completed by Employee)

Surname: \_\_\_\_\_ Given Name(s): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male  Female

Address: \_\_\_\_\_ Postcode: \_\_\_\_\_

Tel. (AH): \_\_\_\_\_ Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

Please complete all of Part D and send form to: Occupational Health Nurse, at the Occupational Health Service (<http://www.hr.unimelb.edu.au/advicesupport/ohs>), Level 1, 138-146 Cardigan St, Carlton Vic. 3053

### Part B - Employment Details (to be completed by Supervisor)

Appointment type:  Continuing  Fixed term  Casual

Employment:  Full time  Part time % \_\_\_\_\_ Time/Hours per week

Duration of Employment: From \_\_\_\_\_ to \_\_\_\_\_

**Location of Lab/Office:** Building: \_\_\_\_\_ Level: \_\_\_\_\_ Room: \_\_\_\_\_

Please Use if Building: \_\_\_\_\_ Level: \_\_\_\_\_ Room: \_\_\_\_\_

Multiple areas apply: Building: \_\_\_\_\_ Level: \_\_\_\_\_ Room: \_\_\_\_\_

Brief Description of Job Responsibilities and role [to be completed by Supervisor]:

\_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Supervisor's Signature: \_\_\_\_\_

Email Address: \_\_\_\_\_ Tel: \_\_\_\_\_

*Occupational Health Nurse notes:*

## Part C - Hazard List (to be completed by Supervisor)

Employee's Name: \_\_\_\_\_

Please indicate (by placing X in each relevant box) whether the work the employee will be carrying out involves any of the following hazards and **SPECIFYING** the nature of any potentially harmful substances.

**Manual handling & Ergonomics:** Supervisors to organize Manual Handling training and Ergonomic Review of Work Area Ref to: EHS Manual 2.5.6.3. Mandatory Training, [www.unimelb.edu.au/ehsm/2.html#2.5](http://www.unimelb.edu.au/ehsm/2.html#2.5).

1.  Lifting weights of > 10 kg or repetitive - Specify: \_\_\_\_\_
2.  Word Processing/Data Entry/Computer use for > 2 hours consecutively.

**Noise & Respiratory Hazards:** Supervisors to ensure staff attend for Hearing and Lung Function Testing within 3 months of commencement at Occupational Health Service: <http://www.hr.unimelb.edu.au/advicesupport/ohs>

3.  High noise levels requiring hearing protection - Specify type of machinery: \_\_\_\_\_
4.  Operations producing dust i.e. Lung irritants; Welding; Epoxy resins.
5.  Scuba diving.

**Hazardous Substances:** Supervisors to ensure staff have Haz Sub Training, Ref to EHS Manual 5.2.2. Hazardous Substances: [www.unimelb.edu.au/ehsm/5.html#5.2](http://www.unimelb.edu.au/ehsm/5.html#5.2). Please refer to list of Scheduled Hazardous Chemicals (<http://tiny.cc/bo4yx>) for guidance.

6.  Hazardous substances including:  Toxic solvents  Heavy metals  Hydrofluoric acid  
Please Specify Haz Subs: \_\_\_\_\_  
 Schedule 1 or 2 Carcinogens  Cyanide,  Others - Specify: \_\_\_\_\_
7.  Herbicides and pesticides - specify: \_\_\_\_\_

**Microbial/Biological:** Supervisors to ensure staff arrange for appropriate vaccination within 3 months of commencement at Occupational Health Service: <http://www.hr.unimelb.edu.au/advicesupport/ohs>

8.  Recombinant DNA, circle class of Laboratory.  PC2  PC3  PC4
9.  Infectious micro-organisms – Specify: \_\_\_\_\_
10.  Use or care of animals – indicate/specify animals:  Native Fauna  Rodents  
 Cattle/Sheep/Goats:  Cats & Dogs  Bats  Pigs  
 Poultry & Other birds.  Others - Specify: \_\_\_\_\_
11.  Visiting an abattoir or working with samples from an abattoir.
12.  Unfixed human blood or tissue. Specify Type: \_\_\_\_\_
13.  Childcare.  Staff or Student Welfare.
14.  Catering (Handling of food):
15.  Exposure to sewerage or rubbish collection.
16.  Incidental work requiring any of the above. Specify: \_\_\_\_\_

**Laser & Radiation:** For Laser & Radiation Ref to: EHS Manual 5.4 Non-Ionising Electromagnetic Radiation [www.unimelb.edu.au/ehsm/5.html#5.4](http://www.unimelb.edu.au/ehsm/5.html#5.4) & 5.5 Ionising Radiation: <http://www.unimelb.edu.au/ehsm/5.html#5.5>. Staff are required to have Visual acuity checks prior to and post laser project as per Standards Australia AS AS2211 Lasers. Contact Department of Optometry & Vision Sciences: <http://www.university-eyecare.org.au/>

17.  Ionizing Radiation: Specify: \_\_\_\_\_
18.  Lasers - class 3 or higher: Specify: \_\_\_\_\_
19.  UV Radiation i.e. Outdoor workers.

### Other non specific risks:

20.  Other hazardous equipment being used. Please Specify: \_\_\_\_\_
21.  Other potential hazards not mentioned above. Please Specify: \_\_\_\_\_
22.  **No Risks identified.**

Supervisor's Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Part D – (to be completed by Employee)**

Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prospective employees may be required to attend a medical examination following assessment of the HHAQ. For assistance in completing this form please contact the Occupational Health Service on 8344 4534 or 8344 8182.

**MEDICAL HISTORY**

Please list all pre-existing injuries and diseases which you are aware of having suffered or sustained which could reasonably be expected to be affected by the nature of this proposed employment.

**The following information will remain confidential and with the Occupational Health Service.**

Do you have, or have you had any of the following conditions? If necessary more space is provided on the next page. Place indicate by placing an X in each relevant box and specifying issues relating to the condition.

Medical Condition	Place X if relevant	Comment
Heart Disease. Stroke. High blood pressure.	<input type="checkbox"/>	_____
Cancer of any kind including leukemia and lymphoma.	<input type="checkbox"/>	_____
Diabetes or other endocrine disorder	<input type="checkbox"/>	_____
Anaemia or other blood disorder.	<input type="checkbox"/>	_____
Epilepsy, loss of consciousness, migraine.	<input type="checkbox"/>	_____
Psychiatric illness, such as anxiety or depression.	<input type="checkbox"/>	_____
Colour blindness, severe problems with vision.	<input type="checkbox"/>	_____
Hearing loss, tinnitus, giddiness	<input type="checkbox"/>	_____
Asthma, hay fever, allergies, sensitivities.	<input type="checkbox"/>	_____
Liver disease, other gastro-intestinal disorder.	<input type="checkbox"/>	_____
Diseases of the genito-urinary systems.	<input type="checkbox"/>	_____
Fractures, dislocations, sprains, joint pains, overuse injuries, whiplash, back pain.	<input type="checkbox"/>	_____
Eczema or other skin disorders.	<input type="checkbox"/>	_____
Tuberculosis, Malaria or other infectious disease.	<input type="checkbox"/>	_____
Have you ever been exposed to asbestos?	<input type="checkbox"/>	_____
Other problems not listed above, describe.	<input type="checkbox"/>	_____
Are you currently on any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

If yes please provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Part D - (To be completed by Employee....continued)**

Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Have you been immunised or been exposed to any of the following?

**Please indicate if you have received a vaccination for the following and the year of last vacation or year of exposure.**

Vaccination	Yes/ No	Year	Vaccination	Yes/ No	Year
Q-Fever	<input type="checkbox"/>	_____	Meningococcal Meningitis	<input type="checkbox"/>	_____
Hepatitis A	<input type="checkbox"/>	_____	MMR (Measles, Mumps, Rubella)	<input type="checkbox"/>	_____
Hepatitis B	<input type="checkbox"/>	_____	Chicken Pox (Varicella)	<input type="checkbox"/>	_____
Polio/Sabine	<input type="checkbox"/>	_____	Whooping Cough (Pertussis)	<input type="checkbox"/>	_____
Tetanus/Diphtheria	<input type="checkbox"/>	_____	Have you completed your childhood tetanus vaccinations (x 5)	<input type="checkbox"/>	

Have you had a blood test to check Hepatitis B antibodies after vaccination?  Yes  No

If yes, were the levels satisfactory?  Yes  No Year of blood test: \_\_\_\_\_

Have you had a TB test (Mantoux)?  Yes  No Year: \_\_\_\_\_ Result: \_\_\_\_\_

If positive have you had any follow up since result (please specify): \_\_\_\_\_

**Have you read and understood the requirements of the supplied position description and the list of health hazards associated with the position as shown in Part B and C?**  Yes  No

**Do you have any past or present medical conditions which may create additional risks for you in undertaking this position?**  Yes  No

If YES please specify: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**I declare that the above information is, to my knowledge, a true and accurate account of my past and present health.**

**New Staff and Graduates: Please note:** Section 82(7) & (8) of the Accident Compensation Act (<http://tinyurl.com/3jt5bl>) will apply so as to provide that failure on your part to disclose any such pre-existing injury or disease or that the making of a false or misleading disclosure will disentitle you to compensation for any recurrence, aggravation, acceleration, exacerbation or deterioration of the pre-existing injury or disease arising out of or in the course of or due to the nature of employment with the University.

Signature of prospective staff member/Graduate: \_\_\_\_\_ Date: \_\_\_\_\_

Information collected on this form will become part of your employment record. It will be stored securely and only used or released in accordance with the University's privacy policy (refer: [www.unimelb.edu.au/unisec/privacypolicy.htm](http://www.unimelb.edu.au/unisec/privacypolicy.htm))

Medical condition details from previous page if applicable.

\_\_\_\_\_  
 \_\_\_\_\_