

**STAFF HEALTH QUESTIONNAIRE**  
**(Outpatient Facilities Only)**

**All staff and volunteers whose functions require or necessitate contact with participants or food preparation shall complete a health questionnaire.**

Name: \_\_\_\_\_

Job Title: \_\_\_\_\_

1. Do you have any serious health problems or illnesses that may be contagious to others around you?

No       Yes       if yes, please give details: \_\_\_\_\_

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

2. Do you have limitations on your ability to perform the work described in your job description and/or duty statement?

No       Yes       if yes, please give details: \_\_\_\_\_

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

3. Do you have any health conditions that would create a hazard to participants or other staff?

No       Yes       if yes, please give details: \_\_\_\_\_

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

**I declare that the above information is true and correct to the best of my knowledge:**

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE