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**Occupational Health Service**

**The University of Manchester**

**CONFIDENTIAL**

**PRE-ACCEPTANCE MEDICAL FITNESS ASSESSMENT**

***To be used by offer holders for undergraduate and postgraduate courses in the following areas:-***

***Medicine, Nursing and Midwifery, Social Worker, Audiology, Speech & Language Therapy, Dentistry, Oral Health Sciences, Optometry, Pharmacy, Clinical Psychology, PGCE, School Direct & Teach First.***

***Medical fitness assessment may also be required where research projects, or taught modules within a programme, involve certain types of laboratory work or have a significant clinical component. A full list of courses requiring medical fitness assessment can be found in the Procedure for admitting applicants to courses that require a medical fitness assessment at :-***

[***http://www.manchester.ac.uk/study/undergraduate/applications/after-you-apply/receiving-offer/***](http://www.manchester.ac.uk/study/undergraduate/applications/after-you-apply/receiving-offer/)

Now that you have been made a conditional / unconditional offer of a place to study at The University of Manchester we need to be aware of any disabilities or health conditions which could be relevant to your proposed course of training and future employment. Such information will be carefully considered in advising on your medical suitability for your proposed course. Where considered appropriate we can then advise your chosen School of the need to consider any reasonable adjustments in light of the level of fitness required to complete the course.

The University of Manchester is committed to providing equality of opportunity for disabled students and where possible all reasonable support will be provided to enable you to complete the course. However, for those undertaking healthcare studies / professional programme, we need to ensure that you will be able to fulfil the competency standards of the course and of the relevant regulatory body (e.g. GMC/ GDC/ NMC etc) and following graduation be fit to practice within their chosen field.

In the rare case that it is decided that you are not medically fit for the course The University will provide you with advice and will make every endeavour to offer you a place on an alternative course.

You have a duty to provide all relevant, truthful and accurate information to The University’s Occupational Health Service and no information should be withheld. Any failure to do so may result in the offer of a place being withdrawn or reconsideration of your fitness to continue with the course.

You can be assured that the information will remain confidential to the staff of the Occupational Health Service. The School will only be informed of the functional effects of any health concerns / disability if this is relevant to your educational needs or pupil/ patient safety and of the need to consider reasonable adjustments and/ or additional support.

Please start by completing **Section 1** whichcovers personal details etc. In **Section 2** you are asked to provide information regarding your medical history and current medical condition / functional capacity etc. Please ensure that all relevant details are included as this will help to avoid the delays involved with approaching you for further information. Having completed Section 1 and Section 2 and the declaration please arrange for your General Practitioner to complete **Section 3** which includes your vaccination history. The completed document should then be placed and sealed in an envelope FAO the University Occupational Health Service ***and return to address as advised by the School / Admissions Administrator.***

**\*\*It is essential that the completed form is returned as soon as possible and certainly within a month of receipt.**

**For applicants applying through ‘Clearing UCAS’, time is severely limited and we require the form to be returned within 2 weeks.**

**Please note that you are responsible for:-**

* **Any fee charged by your General Practitioner for completing the form; and**
* **Ensure that correct/ adequate postage is used to return form (normally large letter stamp).**

Having given careful consideration to your completed form the Occupational Health Service may contact you for further information / to arrange an appointment.

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| --- |
| **SECTION 1** |

**Personal Details:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| University User ID |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
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 |
| Family Name: | Forename: |
| Title: | Date of Birth: |
| Nationality:  | Sex: M / F |

|  |  |
| --- | --- |
| **University Term Time Address (if known)** | **Vacation / Home Address** |
| (1) | (2) |  |
| Postcode: | Postcode: | Postcode: |
| Tel No: | Tel No: | Tel No: |
| Mobile: | Mobile: | Mobile: |
| Email: | Email: | Email: |

|  |  |  |
| --- | --- | --- |
| **GP’s Name and Address** | **Term Time** | **Vacation (if relevant)** |
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|  |  |  |
|  |  |  |
| Tel No: | Tel No: | Tel No: |

**Course Details:**

|  |  |
| --- | --- |
| Name the course you have an offer for: |  |
| Month & Year you intend to start the course: |  |
| Length of course |  |

**Work / Employment History:** (if applicable)

|  |  |  |  |
| --- | --- | --- | --- |
| **Nature of Work** | **Employer** | **Start Date** | **Finish Date** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| Have you ever had to finish or leave work on health grounds?(Please **✓** as applicable) | Yes | No |
| If **yes**, please supply details including dates. |
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|  |  |  |
| --- | --- | --- |
| Have you ever previously registered at a higher education college/ University for a course of study?(Please **✓** as applicable) | Yes | No |
| If **yes**, please supply details including dates. |
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|  |  |  |
| --- | --- | --- |
| **Name of College / University** | **Start Date** | **Leaving Date** |
|  |  |  |

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| --- |
| If you failed to complete the course, please provide details: |
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| **SECTION 2** |

**Your Health and Functional Capabilities:**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **1** | **Do you have problems with any of the following:-** |  |  |
|  | a. | **Mobility?** e.g., walking, using stairs, balance: |  |  |
|  | b. | **Agility?** e.g., bending, reaching up, kneeling down: |  |  |
|  | c. | **Dexterity?**  e.g., getting dressed, writing, using tools: |  |  |
|  | d. | **Physical Exertion?** e.g., lifting, carrying, running: |  |  |
|  | e. | **Communication?** e.g., speech, hearing: |  |  |
|  | f. | **Vision?** e.g., visual impairment, colour blindness, tunnel vision: |  |  |
| If **YES** to any of the above, please give full details (e.g., extent of impairment, how you manage, support needs): |
|  |
|  |
|  |
|  |
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|  |  |  |  |
| --- | --- | --- | --- |
| **2.** | **Have you ever required special arrangements during your studies / work to accommodate a disability or health concern? (e.g. special equipment, extra time in exams, part-time working)?** | **Yes** | **No** |
| If **YES** please give details: and an indication of date and duration etc |
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|  |  |  |  |
| --- | --- | --- | --- |
| **3** | **Do you have, or have you had, any of the following?** | **Yes** | **No** |
|  | a. | **Chronic Skin Condition?** e.g., eczema, psoriasis. |  |  |
|  | b. | **Neurological Disorder?** e.g., epilepsy, multiple sclerosis. |  |  |
|  | c. | **Allergies?** e.g., latex, medicines, foods. |  |  |
|  | d. | **Endocrine Disease?** e.g., diabetes. |  |  |
|  | e | **Hep B/ Hep C/ HIV?** |  |  |
| If **YES** to any of the above please give details including a diagnosis, an indication of date and duration etc (e.g. when condition developed, severity, effects and treatment / medication): |
| For (a) please also stipulate areas affected:  |
|  |
|  |
|  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **4** | **Have you ever been affected by:** | **Yes** | **No** |
|  | a. | **Sudden Loss of Consciousness?** e.g., fit or seizure: |  |  |
|  | b. | **Chronic Fatigue Syndrome?**(or similar condition): |  |  |
|  | c. | **Mental Health Issues?** e.g., anxiety, depression, phobias, OCD, nervous breakdown, personality disorder, over-dose or self-harm, drug or alcohol dependency: |  |  |
|  | d. | **An Eating Disorder?** e.g., bulimia, anorexia nervosa, compulsive eating: |  |  |
|  | e. | **An illness requiring more than two weeks’ absence from school or work?** |  |  |
| If **YES** to any of the above please give details including an indication of date and duration etc (e.g. when condition developed, severity, effects and treatment / medication): |
|  |
|  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **5** | **Have you ever received treatment from a psychiatrist, psychotherapist or counsellor?** | **Yes** | **No** |
| If **YES** to any of the above please give details including an indication of date and duration etc (e.g. when condition developed, severity, effects and treatment / medication): |
|  |
|  |
|  |

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **6** | **Are you currently taking any medication or treatment?** |  |  |
| If **YES**  please give details: including current dose |
|  |
|  |
|  |

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **7** | **Do you have any disability or health condition not already mentioned for which you think you may require support during your employment/ education or training?** |  |  |
| If **YES** to any of the above please give details: |
|  |
|  |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **8** | **What is your height?** |  | **What is your weight?** |  |

**If you would like any further advice to discuss the implications of your health in relation to your course, please contact:**

1. ***For all Undergraduate Courses:***

**The Occupational Health Service, Waterloo Place, Oxford Road - Tel: 0161 275 2858**

**Fax: 0161 275 3137**

1. ***For PG, PGCE, School Direct & Teach First & MA Social Work:***

**B22 The Mill, Sackville Street, Manchester M13 9PL – Tel: 0161 306 5806**

**Fax: 0161 306 3245**

**Note: Please ensure you have answered ALL questions and provided appropriate details. This will help us to make an assessment as quickly as possible and avoid unfortunate delays.**

**Declaration:**

I certify that my answers to the questions are complete, accurate and no information has been withheld. I understand that if this is later shown not to be the case it may result in the offer of a place being withdrawn or reconsideration of my suitability to continue with my course.

The information supplied by you on this questionnaire will be used to assess your medical suitability to commence your course. A certificate will be provided and forwarded to your School.

I give my consent for my General Practitioner/Doctor to provide the medical staff at the University Occupational Health Service with any medical information relevant to my application.

|  |  |  |
| --- | --- | --- |
| **Name:** | **Signature:** | **Date:** |

**Please take completed and signed form together with your vaccination record to your General Practitioner/Doctor and request that he / she completes the enclosed form.**

**Please note that we ask that the completed form is returned within a month of receipt. For Students applying through ‘Clearing UCAS’, time is severely limited and we require the form to be returned within 2 weeks.**

**You will be responsible for any fee if this is required by your General Practitioner/Doctor.**

|  |
| --- |
| **Data Protection Information**If you join the University this questionnaire will form the basis of your Occupational Health record. If you do not join, your questionnaire will be destroyed.* Records are held in confidence by The University’s Occupational Health Service.
* No identifiable medical or other information you provide in confidence and contained in your Occupational Health record will be released by the Occupational Health Service to anyone else without your consent being obtained.
* You may obtain access to your Occupational Health record by contacting the Occupational Health Service.
* The University of Manchester will not share your information with any third party. For further information of your rights to access data which we hold about you please contact the Records Management Office Tel: 0161 275 8111 and e mail dataprotection@manchester.ac.uk
* **Please return your completed Pre–Acceptance Medical Fitness Assessment:**
* **AS ADVISED BY YOUR SCHOOL**

Occupational Health Services, Waterloo Place, 182-184 Oxford Road, Manchester M13 9GPTel: 0161 275 2858 Fax: 0161 275 3137Occupational Health Services, B22 The Mill, Sackville Street, Manchester M13 9PLTel: 0161 306 5806 Fax: 0161 306 3245 (PGCE, School Direct & Teach First, MA Social Work or any PG course only) |

**VACCINATIONS & DISEASES**

**Please give details of your vaccinations or known illness against the following diseases. These details may be available from your general practitioner’s/Doctor’s medical records. If your General practitioner/Doctor is not in full possession of your vaccination history please contact your local Child Health Records Department, which is based at your local Health Authority. Any further screening / vaccination procedures will be undertaken by Occupational Health, early into your course.**

|  |
| --- |
| **BCG (Tuberculosis):**  |
| What is your country of birth? |
|  | **Yes** | **No** |
| Have you had Tuberculosis: |  |  |
| Is there a family history of Tuberculosis? |  |  |
| Have you lived or worked abroad for a period greater than 3 months? |  |  |
| If **YES** please give details of:  |
| Date: |
| Country: |
|  | **Yes** | **No** |
| Have you been vaccinated against Tuberculosis? |  |  |
| If **YES** please give details of: |
| Date of Tuberculosis vaccination (BCG): |
|  | **Yes** | **No** |
| Do you have a visible scar (usually located on the upper arm)? |  |  |
| Have you had a recent chest x-ray? |  |  |
| If **YES** please supply details of dates and location: |
|  |

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| --- |
| **MMR (Measles, Mumps and Rubella) / Varicella (Chicken Pox)** Please specify: |
| **I have had the following disease(s):** | **Yes** | **No** | **Don’tKnow** | **I have received the following vaccinations:** | **Yes** | **No** | **Date Received:** |
| Measles: |  |  |  | Measles: |  |  |  |
| Mumps: |  |  |  | Mumps: |  |  |  |
| Rubella: |  |  |  | Rubella: |  |  |  |
|  |  |  |  | MMR please note that 2 are required): |  |  |  |
| Chicken Pox: |  |  |  | Varicella: |  |  |  |

|  |
| --- |
| **Hepatitis B:** |
|  | **Yes** | **No** |
| Have you previously worked with human tissue, blood or bodily fluids? |  |  |
| Have you ever been offered Hepatitis B vaccinations? |  |  |
| If **YES** please provide the following dates and details: |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of 1st Dose** | **Date of 2nd Dose** | **Date of 3rd Dose** | **Date of blood test** | **Result of blood test lµ/l** | **Date of Booster** |

|  |
| --- |
| **Other:** |
| **Vaccinations:** | **Dates Of Vaccinations:** |
| Pertussis (Whooping Cough) | 1st | 2nd | 3rd |  |  |
| Polio | 1st | 2nd | 3rd | 4th | Booster |
| Tetanus | 1st | 2nd | 3rd | 4th | Booster |
| Diphtheria | 1st | 2nd | 3rd | 4th | Booster |
| Meningitis ACWY |  |  |  |  |  |
| Other (specify) |  |  |  |  |  |

**Please ensure that you have answered ALL of the questions. Your assessment cannot be completed until you do.**

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| **SECTION 3** |

**General Practitioner’s / Doctor’s Certificate**

Your patient has been offered a place to study at The University of Manchester. All prospective applicants undertaking a course subject to the requirements of a regulatory body e.g. GMC / GDC / NMC etc., are required to complete a medical assessment to enable the University to assess their medical fitness and where appropriate consider any reasonable adjustments or additional support needs.

We would ask for your co-operation in verifying the health information provided by the prospective applicant. I appreciate that you are extremely busy but the time is limited to undertake all the necessary screening we would be most grateful if you could therefore complete the form as soon as possible.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Please ✓ the appropriate answer | **YES** | **NO** |
| 1. | Are you the applicant’s usual General Practitioner / Doctor? |  |  |
| 2. | Are you the relative of the applicant? |  |  |
| 3. | Do you hold the applicant’s medical record? |  |  |
| 4. | According to your records and knowledge of the applicant, do the answers to questions in Section 2 appear correct / full / accurate?(please add any comments below, if appropriate) |  |  |
|  | Comments: |  |  |
|  |  |  |  |
|  |  |  |  |
| 5. | Are you aware of any additional medical information which may be relevant to this application?(if **yes** please provide details) |  |  |
|  | Details: |  |  |
|  |  |  |  |
|  |  |  |  |

Practice Stamp

General Practitioner’s / Doctor’s Signature:

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

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE NOTE: A medical examination is not required.**

**Any fee required for completion of the form is the responsibility of the patient**

***Thank you for your co-operation in completing this form***

|  |
| --- |
| Following discussions with the British Medical Association and others it has been agreed that this medical assessment form will also be accepted by the following universities:Peninsula Medical School Queen’s University Belfast University of GlasgowUniversity of Oxford The University of Manchester The University of Sheffield |

**DOCUMENT CHECK LIST**

**Please ensure that you have received / completed the following documents**

**Numbers 2/ 3/ 4 should follow this page:-**

|  |  |
| --- | --- |
| 1. Pre-Acceptance Medical Fitness Assessment
 | Fully completed, signed and stamped by General Practitioner. |
| 1. Informed consent/ further medical information:
 | Received and read. |
| 1. Consent form
 | Received and completed. |
| 1. Letter for General Practitioner/ Doctor.
 | Received and issued / to General Practitioner / Doctor. |

**APPLICANTS FOR BMIDWIFERY ONLY**

|  |
| --- |
| * Blood Bourne Virus (BBV) clearance is a mandatory requirement for Midwifery.
 |
| * Please see/read the further information/guidance attached (Page 16)
 |
| * Midwifery applicants will be contacted and offered an appointment to attend ***(on receipt of their*** ***Pre-Acceptance Health Questionnaire***), for BBV blood test.
 |
| * It is essential we receive your fully Completed HQ by the deadline advised by the School
 |
| * A fully completed Pre-Acceptance Health Questionnaire ***and*** attendance for BBV blood test is required before Medical Suitability to Commence on the Course can be confirmed.
 |

**INFORMED CONSENT / FURTHER MEDICAL INFORMATION**

In the event that you have provided us with details of a current, or past, medical condition it would be helpful, and will reduce the time to complete your medical assessment, if you can please complete the enclosed “Consent Form” giving the full contact details of any specialists (medical, psychological etc.,) involved in your care and include this when returning the form.

This will provide the necessary informed consent for us to write for further information if considered appropriate to do so.

If for any reason you wish to discuss this further please contact:-

|  |  |  |
| --- | --- | --- |
| **Course** | **Contact Name** | **Contact Details** |
| Undergraduate Nursing, Midwifery & Social Work/ Medicine / Dentistry / Oral Health Sciences / Pharmacy / Speech & Language Therapy / Healthcare Science (Audiology) / Optometry | Ms Fliss Anderson | 0161 275 2862 fliss.anderson@manchester.ac.uk |
| Postgraduate Dentistry / Audiology / Teach First/ PGCE/ MA Social Work | Miss Pauline Hollinshead | 0161 275 0970pauline.hollinshead@manchester.ac.uk |

|  |  |
| --- | --- |
| university-1 | **Occupational Health Service****The University of Manchester****www.occhealth.manchester.ac.uk** |

#### CONSENT FORM

|  |  |
| --- | --- |
| **Name:** |  |
| **Date of Birth:** |  |
| **Home Address:** |  |
|  |  |
|  |  |
|  |  |
| **Home Telephone No:** |  |
| **Mobile Telephone No:** |  |
| **Email address:** |  |

|  |  |
| --- | --- |
| **GP’s Name:** |  |
| **GP’s Telephone No:** |  |

|  |  |
| --- | --- |
| **Specialist’s Name:** |  |
| **Address:** |  |
|  |  |
|  |  |
|  |  |
| **Telephone No:** |  |
| **Hospital No (if known):** |  |

I understand my rights under the Access to Medical Reports Act 1988 and have read the guidance overleaf.

I hereby consent to a medical report being supplied in confidence to the Consultant Occupational Physician named above.

**I DO** / **DO NOT \*** wish to see any medical report before it is supplied.

Signed:……..………….…………………………………………Date: …………………………

**\***delete as appropriate

##### ACCESS TO MEDICAL REPORTS ACT 1988

The University of Manchester cannot apply to a doctor who has been responsible for your care for a medical report without your consent.

|  |  |
| --- | --- |
| **1.** | **If you give consent:** |
|  | (a) |  | You may also indicate overleaf that you wish to see the report before it is sent on to the Occupational Health Service. If so you have the right: |
|  |  |  | (i) If requested, to receive a copy of the application for a medical report. |
|  |  |  | (ii) You have 21 days from that date to make your own arrangements with your doctor to see the report. If you want a printed copy your Doctor may charge you a fee. |
|  | (b) |  | If you do not indicate overleaf that you wish to see the report, you may still contact your doctor asking to see it, and (provided the report has not already been sent) you will then have 21 days to make arrangements to see it before it is sent on. |
|  | (c) |  | Your doctor must keep a copy of the report (which you may ask to see) for 6 months afterwards. |
| **2.** | **When you have seen the report you may:** |
|  | (a) |  | Ask the doctor to change any part which you think is inaccurate or misleading. |
|  | (b) |  | Ask the doctor to attach to the report your version on that part, if the Doctor does not agree to change it. |
|  | (c) |  | Refuse to allow the report to be sent on. |
| **3.** | **A doctor need not show you any part of a medical report which would:** |
|  | (a) |  | Be likely to harm your physical or mental health |
|  | (b) |  | Be likely to harm the physical or mental health of someone else. |
|  | (c) |  | Reveal the identity of a third party, other than another health professional who wants to remain anonymous. |
|  | (d) |  | Reveal the doctor’s intentions about you. |
| **4.** | Under the Data Protection Act 1998 you also have the right to see your own health record, i.e. all the records which your General Practitioner or specialist is holding about you. The Occupational Health Service is not asking for a copy of all your records and the University has no right to order you to produce these. All that is being requested is a report on your current state of health as it is affecting your work and the likely predictions for the future. If you are concerned about this you should discuss the matter with your GP. |

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| --- | --- |
| university-1 | **Occupational Health Services**Waterloo Place, 182/184 Oxford Road, Manchester M13 9GPTelephone: 0161 275 2858 Fax: 0161 275 6989 |

To the General Practitioner

Dear Doctor

**Re: Applicants offered a place to study**

Your patient has recently applied to study at The University of Manchester starting next September.

The proposed course is one subject to regulations and a s a result we would be grateful if you would complete the General Practitioner’s / Doctors certificate at the end of the Pre-Acceptance Medical Fitness Assessment which has been handed in to your Practice.

I appreciate that you are extremely busy but there is a limited time to consider your patient’s medical fitness to start the course. as a result I would be most grateful if you can complete the form as soon as possible.

You will note that any required fee is the responsibility of the applicant.

Thank you for your help and cooperation.

Yours faithfully

**Occupational Health Service**

|  |  |
| --- | --- |
| university-1 | **Occupational Health Services**Waterloo Place, 182/184 Oxford Road, Manchester M13 9GPTelephone: 0161 275 2858 Fax: 0161 275 6989 |

**SCREENING HEALTHCARE WORKERS (HCW’s) FOR BLOOD BORNE VIRUSES (BBV’S):**

**(HEPATITIS B & C & HIV) – FAO NURSES & MIDWIVES ONLY**

In 2007 the Department of Health published *“Health Clearance for Tuberculosis, Hepatitis B, Hepatitis C and HIV: New Healthcare Workers”*. This guidance recommends that all new healthcare workers have checks for Tuberculosis disease/ immunity and are offered Hepatitis B immunisation, with post-immunisation testing of response and the **offer** of tests for Hepatitis C and HIV.

The guidance goes on to advise that for new healthcare workers who perform **exposure prone procedures**, **additional health clearance** should also be undertaken. Additional health clearance means being non-infectious for HIV (antibody negative) Hepatitis B (surface antigen negative or, if positive, e-antigen negative with a viral load of 10³ genome equivalent/ml or less) and Hepatitis C (antibody negative or, if positive, negative for Hepatitis C RNA).

**Exposure prone procedures (EPP’s)** are those invasive procedures where there is a risk that injury to the worker/ student may result in the exposure of the patient’s open tissues to the blood of the worker/ student. These include procedures where the worker’s/student’s gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (e.g. spickles of bone or teeth) inside a patients open body cavity, wound or confined anatomical space where the hands or finger tips may not be completely visible at all times.

Prospective **Midwifery Students** will require this additional health clearance and will therefore be screened for blood borne viruses **prior** to registration. This is because some of the core competencies of work as a Midwife involve procedures which could be considered to involve exposure prone procedures.

Performance of EPP’s is not a requirement of the curriculum for pre-registration student **nurse** training however testing will be **offered** to nurses on commencement of the course. The following guidance gives information on ways in which exposure to HIV may have taken place:

|  |
| --- |
| * a male engaging in unprotected sexual intercourse with another man;
* unprotected intercourse in, or with a person who had been exposed in, a country where transmission of HIV through sexual intercourse between men and women is common;
* sharing injecting equipment while misusing drugs;
* having a significant occupational exposure to HIV-infected material in any circumstances;
* engaging in invasive medical, surgical, dental or midwifery procedures, either as a practitioner or patient, in parts of the world where infection-control precautions may have been inadequate, or with populations with a high prevalence of HIV infection;
* engaging in unprotected sexual intercourse with someone in any of the above categories.
 |

Practising HCWs who undertake EPP’s are under a professional duty to seek medical advice on the need to be tested as soon as they are aware they may have been exposed to HIV infection, occupationally or otherwise (e.g. if they meet any of the preceding exposure criteria) and if found to be positive, to obtain and follow appropriate clinical and occupational health advice.

Being HIV positive, or declining a test for HIV, will not affect the employment or training of HCW’s who will **not** perform EPP’s.

**Procedure for Screening at The University of Manchester**

The University of Manchester is committed to protecting students/staff and their patients from blood borne viruses (BBV’s) and preserving confidential personal records for Staff and Students. The vast majority of nursing and medical duties do not pose a risk of infection to or from patients, provided that normal infection control precautions are observed.

Screening is only undertaken with informed consent and is in line with national guidance. Staff who test positive for a blood borne virus will receive confidential, expert advice from the Occupational Health staff and where necessary and appropriate will be referred through their General Practitioner to the Specialist Services for further advice and possibly treatment. Each case will be considered individually in consultation with the Specialist Services and where possible advice will be given regarding reasonable adjustments which may include restrictions from certain areas of work e.g. restriction from EPP’s.

We recognise that such tests can cause some anxiety. In the event that you have any significant concerns about your personal risk we recommend you to speak with your General Practitioner or the Local Genitourinary Clinic or contact the Occupational Health Service for a confidential discussion.

Please follow the link below to key related Department of Health Guidance:-

*Health Clearance for Tuberculosis, Hepatitis B, Hepatitis C and HIV: New Healthcare Workers 2007*

<https://www.gov.uk/government/publications/new-healthcare-workers-clearance-for-hepatitis-b-and-c-tb-hiv>

*The Management of HIV infected Healthcare Workers who perform exposure prone procedures: updated guidance, January 2014.*

[*https://www.gov.uk/government/uploads/system/uploads/attachment\_data/file/333018/Management\_of\_HIV\_infected\_Healthcare\_Workers\_guidance\_January\_2014.pdf*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/333018/Management_of_HIV_infected_Healthcare_Workers_guidance_January_2014.pdf)