

MEDICAL DISCLOSURE FORM

In order to meet our duty of care obligations all employees, contractors and visitors who intend to undertake activities in our workshop must complete the following questions prior to approval being granted to access workshop areas.

Name: _____ Date: ____/____/____.

Department / Section: _____

Are you aware of any medical or other condition which might affect your capacity to undertake workshop activities involving machinery / equipment (e.g. epilepsy)

- YES
 NO

Are you currently taking any medication or substances which may affect mental alertness and / or coordination. (e.g. prescription medication which is usually labelled by an orange warning stick alerting the user not to drive a motor vehicle or operate machinery whilst taking medication)

- YES
 NO

If you answered YES to either of the above Questions please take the this form to your doctor for signing and return it to the workshop supervisor / manager prior to commencing any activity within the workshop.

Personal Declaration:

I (full name) _____ declare that I have read this Form and that I have completed it to the best of my knowledge and ability, disclosing all relevant facts as they are known to me.

I also undertake to advise the Supervisor / Manger should my circumstance change throughout my employment .

Signature: _____ Name: _____ Date: ____/____/____

Medical Authorisation

The employee requiring this medial authorisation has submitted a medical disclosure form stating that they have a condition or are taking medication which may affect their capacity to work in a workshop environment.

EQUIPMENT & MACHINERY THAT MAY BE USE:

Soldering Iron	Oxy Acetylene Welder	Electric Welder
M.I.G welder	T.I.G. welder	Vacuum Former
Cooking Stove	Scroll Saw	Table Saw
Band Saw	Pedestal Drill	Metal Lathe
Wood Lathe	Disc Sander	Stroke Sander
Vertical Sander	Metal Guillotine	Rollers
Spray Guns	Nail Guns	Sewing Machines

ACTIVITY REQUIREMENTS

- Lifting
 Chemical Usage
 Bending

I, Dr _____ of _____ declare that

Name Practice name

_____ if fit to undertake activities in the workshop and use the equipment as outlined

Patients / Employee name

above.

Signature: _____ Name: _____ Date: ____/____/____