WHARFEDALE
Occupational Health Services

hands on Occupational Health

Surname:	Forename:
Previous Names:	Date of Birth:
Address:	
Telephone Daytime:	Evening:
Job title:	Company:
GP Name and Address:	
How often do you work nights? Permanent/Rotational Shift/ Occasionally/Never	
Please describe your shift pattern.	

Under Working Time Regulations, your employer is obliged to offer any staff working nights the opportunity to have a health assessment before starting to work nights and then at regular intervals, if you do not wish to undergo a health assessment please sign below and do not complete any further sections of the form.

I do not wish to undergo a health assessment at this time however I am aware that I can change my mind and request a health assessment at any time in the future in relation to working nights.	
Signed:	Date:

Note for manager:
Where a person declines the offer of a health assessment, this signed document should be filed in the personal file for your future reference.

If health assessment is required the complete form (both pages) should be sent to:

Wharfedale Occupational Health
PO Box 376
Leeds
LS19 9HN

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COMPLETE THIS SECTION IF YOU WANT TO HAVE A HEALTH ASSESSMENT.

Are you or have you suffered from any of the following?	No	Yes	Details
Diabetes: please give details of how this is controlled			
Epilepsy			
Heart Problems Including angina, blood pressure, heart disease			
Chest/respiratory problems Asthma, bronchitis, COPD			
Stomach/digestion problems			
Mental health problems Stress, anxiety, depression			
Musculoskeletal problems			
Any other medical problem			
Do you need to take medication at regular times of the day			
Any health problem which is affected by your work			
Are you taking medication			
Do you need medication to help you sleep?			
Would you like to discuss your health and work with an occupational health nurse?			

Declaration by the night worker:

I declare that the above information is true to the best of my knowledge. I understand that the detailed clinical information will not be supplied to my employer without consent, although a general recommendation may be made based on the information given and discussed with me.

Signed:	Date:
Print Name:	OH use: phone/appt/fit/GP rep Signed: Print: Designation: Date: