AMBITIONS PERSONNEL

NIGHT WORKER`S HEALTH ASSESSMENT FORM

This form is designed to help assess if you have any health condition which could affect your ability to perform night work. The opportunity for an assessment is required by the Working Time Regulations 1998.
This form asks specific questions about your health.

YOUR NAME	DATE OF BIRTH
JOB TITLE	NI NUMBER (if known)
HOME TELEPHONE NUMBER	HOME ADDRESSS

Please complete this form to the best of your knowledge, and tick the appropriate box(es). Please note that ticking YES does not necessarily mean you are unfit for night work (simply that we will need to refer you for further medical assessment)

1 Do you suffer from diabetes?	YES	NO
2 If yes, does this require treatment with injections on a strict timetable?	YES	NO
3 Do you suffer from a heart or circulatory disorder?	YES	NO
4 If yes, does this affect your physical stamina?	YES	NO
5 Do you suffer from any stomach or intestinal disorder, such as ulcers?	YES	NO
6 Do you have any condition where the timing of a meal is particularly important?	YES	NO
7 Do you suffer from any (medical) condition effecting your sleep?	YES	NO
8 Do you suffer from a chronic chest disorder where night-time symptoms are particularly troublesome?	YES	NO
9 Do you suffer from any other (medical) condition requiring regular medication on a strict timetable?	YES	NO
10 Are you aware of any other health factors that may affect your fitness to do night work? Please use the space overleaf for any additional comments:	YES	NO

Declaration:

I certify that the answers to the above questions are correct to the best of my knowledge.
I understand that if I have withheld information this may adversely effect efforts to place me in suitable employment.

Employees signature…… Date…….

Received by……. Date…….