Name: ……………………………………………………….. Date of Birth: …………………………………………….

Phone: ……………………………………………………….. Job Title: …………………………………………………….

Email:………………………………………………………………………………………………………………………………………………….

**Data Protection**

The information supplied in this questionnaire will be held in confidence by [the organisation] as part of your health record.

Weekly working hours: ……………………………………………………………………………..

**Do you suffer from any of the following conditions?**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Diabetes |  |  |
| Heart or circulatory problems |  |  |
| Stomach or intestinal issues, such as ulcers |  |  |
| Any medical condition which causes problems with sleeping |  |  |
| Chronic chest conditions where night time symptoms may be problematic |  |  |
| Any medical condition requiring medication to be taken on a strict timetable |  |  |
| Any medical condition where the timing of meals is particularly important |  |  |
| Any mental health conditions which may be affected by night work |  |  |
| Any other medical condition which may affect your ability to work safely at night |  |  |

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Are you a new or expectant mother? (Optional question) |  |  |
| If you have worked at night before, did this cause any health issues? |  |  |

If you have answered **‘yes’** to any of the above, please give details……………………………………………………..

…………………………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………………….

Do you think that any of the aforenamed conditions are made worse by night work? Yes No

If you answered ‘yes’, please give details…………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………………….

……………………………………………………………………………………………………………………………………………………………….

Would you like to discuss any of this with a medical practitioner? Yes No

**Declaration**

All the answers given above are true to the best of my knowledge and I understand that no medical details will be divulged without my permission to any person outside [the organisation], but an opinion about my fitness for night work will be issued to management.

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

Print Name: ………………………………………………………

**Office Use Only:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | | **Yes** | **No** |
| Suitable to continue night working? | | | |  |  |
| Requires a medical practitioner telephone review? | | | |  |  |
| Requires a medical practitioner worker health assessment? | | | |  |  |
| Requires a medical practitioner referral? | | | |  |  |
| Recall Date: | Annual | 2 years | 3 years | | |

Staff Signature: ……………………………………………………………………. Date: ……………………………………………….

Position: ………………………………………………………………………………