



HEALTH QUESTIONNAIRE TO ASSESS IF YOU ARE FIT TO WORK NIGHTS

The purpose of this questionnaire is to make sure that you are suited to working at night. All the information you provide will be kept confidential.

About you

Job Title:
Full Name:
Sex: M [] F []
Date of birth:
Permanent address:
National Insurance number:

Health conditions

Do you suffer from any of the following health conditions?

Diabetes Yes [] No []

Heart or circulatory disorders Yes [] No []

Stomach or intestinal disorders Yes [] No []

Any condition which causes difficulties sleeping Yes [] No []

Chronic chest disorders (especially if night-time

Symptoms are troublesome) Yes [] No []

Any medical condition requiring medication to strict timetable Yes [] No []

Any other health factors that might affect fitness at work Yes [] No []

If you have answered 'yes' to any of the above questions, you may be asked to see a doctor or nurse I, the undersigned, confirm that the above is correct to the best of knowledge.

Signed: Date:

Print Name

EMPLOYER'S ASSESSMENT

Your employer should complete the next section with their assessment.

After reviewing the questionnaire, my assessment is that you

can work nights

can not work nights

should see a doctor or nurse for a medical examination to assess whether you can work nights

offered assistance booking medical for Driver

Signed: Date:

Print name