

10. Do you suffer from a chronic chest disorder (such as asthma) where night- time symptoms are particularly troublesome? Yes No
11. Do you suffer from any medical condition requiring regular medication at strict times e.g. epilepsy or thyroid disease? Yes No
12. Have you had depression, "stress", nervous disorders or other mental illness, alcohol or drug addiction? Yes No
13. Are you aware of any other health factors that may affect your fitness to do night work or do you feel night shifts affect your health in any way? Yes No
14. Please use the space below for any additional comments:

Declaration:

I certify that the answers to the above questions are correct to the best of my knowledge and belief.

I understand that if I have withheld information, this may adversely affect efforts to place me in suitable employment.

Employees signature

Date:

Received by:

Date:

For office use only:

Pass to Occupational Health Yes No

For Occupational Health use only:

Fit for night work

Fit for night work with restrictions

Unfit for night work: