|  |
| --- |
| Under the Working Time Regulations (1998) and Amendment Regulations (2003) night workers are entitled to a free health assessment prior to commencing nightshift, and regular health assessments to night workers thereafter. Employees do not have to take the opportunity to have a health assessment, but it must be offered by the employer. This questionnaire is confidential and will be used by the Occupational Health Service to assess your health in relation to night work. However, the occupational health specialist will give an opinion to the Company on your fitness for night work.A night worker is classified as an individual who regularly works for more than three hours during the period 11 p.m. to 6 a.m. The completed questionnaire should be returned directly to the Occupational Health Service. Some personnel performing night work may be advised to attend for a consultation depending on the results of the questionnaire. |
| **Name** |       |
| **Date of Birth** |       |
| **I do not wish to have a Night Worker Health Assessment****(Signature of applicant)** |       |
| **ACC Cluster** |       |
| **Function** |       |
| **Employee no.** |       |
| **Telephone No** |       |
| **Brief outline of Job Description** |       |
| **Type of Night Work****(please tick)** | Continual Night Work | [ ]  | Rotating Shift Pattern | [ ]  | Occasional Night Work | [ ]  |

| **Please answer each question by ticking “YES” or “NO”.** | **Yes** | **No** |
| --- | --- | --- |
| 1. | Have you worked on a night and/or a shift pattern previously? | [ ]  | [ ]  |
| If YES, please provide details:      |
| 2. | Do you take any prescribed medication or undergoing any treatment at present? | [ ]  | [ ]  |
| If YES, please provide details:      |
| 3. | Do you suffer from Insulin dependent diabetes? | [ ]  | [ ]  |
| If YES, please provide details:      |
| 4. | Do you suffer from epilepsy? | [ ]  | [ ]  |
| If YES, please provide details:      |
| 5. | Do you suffer from a sleep disorder? | [ ]  | [ ]  |
| If YES, please provide details:      |
| 6. | Do you suffer from depression? | [ ]  | [ ]  |
| If YES, please provide details:      |
| 7. | Do you suffer from stomach or duodenal ulcers | [ ]  | [ ]  |
| If YES, please provide details:      |
| 8. | Do you suffer from heartburn or indigestion? | [ ]  | [ ]  |
| If YES, please provide details:      |
| 9. | Do you, or have you ever suffered from any heart or circulatory problems? | [ ]  | [ ]  |
| If YES, please provide details:      |
| 10. | Do you have any sleep disturbance problems or difficulties sleeping after night shifts? | [ ]  | [ ]  |
| If YES, please provide details:      |
| 11. | Have you suffered from any anxiety or any mental or depressive illness? | [ ]  | [ ]  |
| If YES, please provide details:      |
| 12. | Are you pregnant, or are you a nursing mother? | [ ]  | [ ]  |
| If YES, please provide details:      |
| 13. | Do you suffer from any health problem which you feel is affected by night work? | [ ]  | [ ]  |
| If YES, please provide details:      |
| **Declaration**I hereby declare to the best of my knowledge and belief that the above answers are true. This information will be held securely by Iqarus Ltd in accordance with the Data Protection Act 2018 and General Data Protection Regulation (EU) 2016.  |
|       |  |  |  |       |
| **Name** |  | **Signed** |  | **Date** |
| Following clinical review of the responses you have made on this questionnaire, one of our occupational health clinical team may need to contact you for further information. |

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| --- |
| **For Occupational Health Use Only** |
| Result  |
|  | FIT | [ ]  |
|  | REFER TO OCCUPATIONAL HEALTH PHYSICIAN | [ ]  |
|  |
| Reason for referral to Occupational Health Physician: |
|       |
|  |  |       |
| **Signature of OHN / OHA** |  | **Date of Questionnaire Review** |

