1 PURPOSE

The purpose of this document is to provide a procedure for the process required for medical assessments pre-, periodic and post-employment or engagement at McArthur River Mine or the Bing Bong Loading Facility (hereafter referred to as MRM). This process will ensue that employees, contractors and visitors are fit for work and not exposed to unacceptable risk whilst performing the work required by their role in accordance with the requirements of Regulation 616 of the *NT Work Health and Safety (National Uniform Legislation) Regulations (2016).*

2 SCOPE

This document details the pre-employment, periodic, transfer and exit health assessment requirements for all MRM employees, contractors and visitors who are on site at MRM at any time for any period of time.

3 LIFE SAVING BEHAVIOURS

- Always come to work drug and alcohol free.
- Always report injuries and HPRI's.

4 PROCEDURE

4.1 Employees and Permanent Contractors Pre-employment Health Assessment requirements

MRM requires candidates for employment to undergo a comprehensive pre-employment medical assessment prior to mobilising to site. These assessments are designed to ensure that the individual is fit for work and able to safely carry out the range of tasks involved in the position they may be employed in. Any operator of heavy mobile equipment will be required to meet the minimum requirements outlined in the Commercial Drivers Standard.

The pre-employment health assessment must include, but is not limited to:

- A screening for substances of abuse and alcohol carried out in accordance with AS/NZS 3547:1997 and AS/NZS 4308:2008.
- A medical assessment conducted, including:
    - Medical history questionnaire;
    - Medical assessment by a General Practitioner or Occupational Physician – to include signed declaration of fitness for work for the intended role;
    - Spirometry, audiometry and visual acuity results;
    - A musculoskeletal Functional Capacity Evaluation (FCE);
    - A baseline blood lead level test, taken during the medical assessment;
    - Any other job specific testing as required, this includes but is not limited to provision of an Electrocardiogram for electrical workers;
    - Any other clinical examinations as requested or required by appropriately qualified clinical personnel or Occupational Physician conducting the assessment.

All of the above documentation is to be reviewed and assessed by the General Practitioner or Occupational Physician.

A copy of the MRM Health Assessment template is attached in Appendix A.

All these requirements must be completed prior to submission of the health assessment to the Site OHN for assessment and review.

All pre-employment health assessments are to be performed by clinical personnel with the appropriate qualifications and experience and authorised by a General Practitioner or Occupational Physician. All information relating to health assessments shall be reviewed by the Site OHN who shall advise Human Resources and the responsible Department Manager on the applicant's suitability to perform the role for which they have applied. If a person is determined unfit for the role they are being assessed for, then the person will not be offered employment in that area or mobilised to site.

The Department Manager may reject the candidate's application for employment if they are advised by the Site OHN that there is a discrepancy between the candidate's physical capacity and the job demands, which may result in an unacceptable level of risk. This is a level of control above the recommendation by the General Practitioner or Occupational Physician.

In determining whether the level of risk for the role is unacceptable, the Department Manager must consult with the Site OHN, and if required, other health professionals involved in the health assessment.

No person shall be offered employment or mobilised to site until the Department Manager seeking to employ the candidate and the Human Resources department receives approval of the pre-employment medical and advice on the candidate's suitability for the role from the Site OHN. No transport or accommodation is to be booked prior to this approval.

4.2 Contractors Pre-employment Health Assessment requirements

The pre-employment assessment must include, but is not limited to:

- A screening test for substances of abuse and alcohol carried out in accordance with AS/NZS 3547:1997 and AS/NZS 4308:2008. This screening must be no more than 14 days old at the time of submission to MRM;
- If the contractor is on site for short term work, such as shutdowns or consulting, then a new screening test for substances of abuse and alcohol is required if there is greater than 90 days away for MRM site.
- A medical assessment and FCE conducted in accordance with the requirements outlined in Section 4.1 of this document;
- The medical assessment must not expire within the timeframe that the person is engaged to be on site at MRM, medical assessments are valid for 12 months;
- A medical which is greater than 30 days old, but less than 12 months old must be accompanied by a supporting declaration from the contracting company stating that the employee has worked for their company since the date of the health assessment and has had no significant health issues since that time;
- An example of the supporting declaration is provided in Appendix B. If this documentation cannot be supplied, a new health assessment shall be conducted and submitted;
- A baseline blood lead level test result;
- Any other job specific testing as required, this includes but is not limited to provision of an Electrocardiogram for electrical workers;
- Any other clinical examinations as requested or required by appropriately qualified clinical personnel or Occupational Physician conducting the assessment;

No Contractors are to be mobilised to site until the health assessment has been approved and authorised by the relevant Department Manager after consultation with Site OHN. Any operator of heavy mobile equipment will be required to meet the minimum requirements outlined in the Commercial Drivers Standard.

A copy of the MRM Health Assessment template is attached in Appendix A.

4.3 Visitors Health Assessment requirements

All visitors to the MRM site will be required to complete a medical questionnaire as part of their visitor's induction. This questionnaire will ensure the Site OHN has all salient information regarding the visitor in the event of an incident or emergency. A copy of the Medical Information Form (FRM-260042) is attached in Appendix C. Access to all medical information provided is restricted to authorised personnel.

4.4 Periodical Health Assessments

Periodic health assessments shall be conducted for all MRM employees and permanent contractors every 2 years in accordance with Regulation 616 of the *NT Work Health and Safety (National Uniform Legislation) Regulations (2016).*

All pre-employment health assessments are to be performed by clinical personnel with the appropriate qualifications and experience and authorised by a General Practitioner or Occupational Physician. All information relating to health assessments shall be reviewed by the Site OHN who shall advise Human Resources and the responsible Department

Manager on the applicant's suitability to continue in the role in which they are employed. Where the Site OHN advises that the health of the worker is at an acceptable level they may continue to work in their normal role.

Where the Site OHN, advises that the health of the worker is at an unacceptable level, the respective Department Manager shall conduct a risk assessment to determine a course of action which may include, but not be limited to:

- Undergoing a further health assessment by appropriately qualified clinical personnel with a recommendation on corrective actions required to improve the health of the worker to an acceptable level;
- Establishing a time based health management plan with a view to the worker returning to their usual role at the conclusion of the plan;
- Continuing the worker in their normal role but on reduced or restricted duties;
- Transferring the worker to an alternate role subject to the training, skills and experience of the worker;
- Requiring the worker to take leave;
- Termination of employment.

MRM shall ensure all obligations are met in accordance with the *Commonwealth of Australia Disability Discrimination Act (1992) and the NT Anti-Discrimination Act (1996).*

4.5 Transfer of Role Health Assessment

A review of an employee's most recent health assessment shall be conducted by the Site OHN to ensure there has been no significant changes which may affect the persons' ability to do the proposed new role. This will be conducted whenever a major change to a worker's role, including physical requirements or conditions of work, is proposed. The review shall ensure that workers are not exposed to unacceptable risk whilst performing the requirements of the new role. Major changes include but are not limited to:

- Transfer from, for example, an administrative role to a machine operators' role;
- Where the physical requirements for the proposed position exceed the person's current position and were not covered during the pre-employment health assessment.

Human Resources will flag the requirement for a Transfer or Role Medical during completion of the Change of Employment Status Form (FRM-2400024). The Department Manager and Site OHN will seek advice from an Occupational Physician to determine if the person being transferred is suitable, or whether an additional health assessment is required.

4.6 Exit Health Assessments

All MRM employees who are terminating employment are requested to undergo an exit health assessment. The minimum requirements for and exit health assessment are:

- A medical assessment conducted in accordance with the requirements outlined in Section 4.1 of this document;
- Blood lead level test.

The assessment shall be forwarded to the Site OHN for review and comparison to the workers previous health assessments. In the event that any detrimental changes in the individual's health are identified, the Site OHN shall inform the Department Manager and the individual and advise them of any recommendations and further assessment or treatment required.

Department Managers shall ensure that personnel under their control who are terminating employment with MRM are given the opportunity to attend an appointed medical provider for an exit health assessment immediately prior to their cessation of employment.

4.7 Health Assessment on request

A health assessment may be requested by a Department Manager where a worker may be suffering from the effects of an injury, illness or medical condition, which may be aggravated by work and compromise the safety of the individual or other personnel thereby resulting in an unacceptable level of risk.

The Department Manager shall advise the worker of the reasons for the health assessment review and arrange for the worker to undergo a health assessment review that may include but not be limited to:

- Medical assessment by a General Practitioner or Occupational Physician – to include signed declaration of fitness for work;
- A musculoskeletal Functional Capacity Evaluation (FCE).

All health assessments requested are to be performed by clinical personnel with the appropriate qualifications and experience and authorised by an Occupational Physician. All information relating to health assessments shall be reviewed by the Site OHN, who shall advise the responsible Department Manager on the applicant's results.

Where the Site OHN advises that the health of the worker is at an acceptable level, they may return to work in their normal role.

Where the Site OHN, advises that the health of the worker is at an unacceptable level, the Department Manager shall conduct a risk assessment to determine a course of action which may include, but not be limited to:

- Undergoing a further health assessment by clinical personnel with the appropriate qualifications and experience at the conclusion of the plan to determine if the health of the worker is at an acceptable level;
- Continuing the worker in their normal role but on reduced or restricted duties;
- The creation of a return to work plan in collaboration with the MRM Rehabilitation and Return To Work consultant to provide a program to get the person back to normal duties in an appropriate timeframe, or assess for alternate duties as required;
- Requiring the worker to take leave;
- Termination of employment.

MRM shall ensure that it meets all obligations under the Commonwealth of Australia Disability Discrimination Act 1992 and the NT Anti-Discrimination Act 1996.

4.8 Communication and documentation of results

All personnel with access to medical information shall ensure the confidentiality of all health assessments is maintained. Where Department Managers are required to discuss information pertaining to health assessments, it shall be done discreetly, maintaining medical in confidence requirements.

Once the pre-employment health assessment has been reviewed by the Site OHN they will notify the relevant Department Manager and Human Resources by email of the prospective employee's suitability for the position. No person is to attend site prior to the Site OHN approval of the medical assessment.

Records of health assessments shall be stored on personnel's site clinical file and with external clinical providers conducting the assessments.

5 ACCOUNTABILITIES

Role	Responsibilities
General Manager	• Authorise the implementation of this procedure.
MRM Management Team	• Ensure all personnel abide by this Procedure and that no person attends site without the required medical assessment.
Environment, Safety and People Team	• Ensure this Procedure is communicated to all relevant personnel and stakeholders. • Provide technical support to line managers when executing their responsibilities as defined in this Procedure.
Superintendents	• Follow responsibilities required in this Procedure for incident reporting and investigation.

	• Ensure this Procedure is communicated to all relevant personnel and stakeholders.
All employees, contractors and visitors	• Comply with the requirements of this Procedure.
External Stakeholders (Contracting companies, medical providers)	• Comply with the requirements of this Procedure.

6 DEFINITIONS

Contractor: A person who is contracted for a specific project or time frame to undertake maintenance or operational activities. This includes personnel engaged for Shutdown maintenance.

Employee: A person who is directly employed by MRM.

Functional Capacity Evaluation: A functional capacity evaluation (FCE) is the profiling of a person's response to a variety of test tasks based upon work and daily activities. The FCE provides an assessment of a person's ability to safely and productively perform the tasks required of their role.

Permanent Contractor: A contracted employee who is employed at MRM on a permanent shift rotation basis.

Site OHN: (Occupational Health Nurse) Registered Nurse qualified person with expertise in occupational health employed or engaged by MRM to provide medical coverage.

Visitor: A person who attends MRM for no more than 7 days (cumulatively) in a 6 month period and is not involved in any work other than that of an administrative nature.

7 DOCUMENT INFORMATION

7.1 References

Commonwealth of Australia. Disability Discrimination Act, 1992.

MRM Drug and Alcohol Procedure. GEN-OHS-PRO-6040-0001.

MRM Health Assessment. FRM-260042.

National Transport Commission. Assessing Fitness to Drive for commercial and private vehicle drivers, 2016.

Northern Territory of Australia. Anti-Discrimination Act, 1996.

Northern Territory of Australia. Work Health and Safety (National Uniform Legislation) Act, 2016.

Northern Territory of Australia. Work Health and Safety (National Uniform Legislation) Regulations, 2016.

Standards Australia. AS 3547:1997. Breath alcohol testing devices for personal use.

Standards Australia. AS 4308:2008. Procedures for specimen collection and the detection and quantitation of drugs of abuse in urine.

8 APPENDICES

Appendix A: **MRM Health Assessment Template**

Medical Assessment Procedure

Health Assessment

McArthur River Mining has a duty under the Work Health & Safety Regulations to implement appropriate health monitoring for workers and contractors.

Name of Individual:			
Date of Birth:		Age:	
Assessment Date:			
Proposed/Current Position/Role:			
Employing Company Name:			
Site			
Employing Company Address:			
Employing Company Phone:		Employing Company Email:	

This section to be completed by the Medical Provider/Occupational Health Nurse/Testing Provider					
Photo ID Sighted:	Yes ☐	Sighted by:		Signature:	

(Note – all sections must be complete. If left unmarked assessment is deemed invalid)

Declaration by the Medical Provider: I hereby certify that the above individual has completed a Health Assessment which has assessed the individuals fitness level to carry out work at the MRM and this assessment had due consideration to the nature of work being conducted. Based on the information received today, the person is: (Please tick the relevant box)

☐	**Low Risk** for the above position (fit for position without restriction)
☐	**Medium Risk** for the above position (comment on the likely actions the individual could take which have the potential to reduce the risk) Comments:_____
☐	**High Risk for the above position** (comment on the likely actions the individual could take which have the potential to reduce the risk) Comments:_____

Test results reviewed by Medical Provider									
ECG (only for electricians)	☐	General Health Assessment	☐	Spirometry	☐	Audiometry	☐	Vision	☐

Fit for the Nature of Work Declared:	Yes ☐	No ☐	(Note – this section must be complete. If left unmarked assessment will default to UNFIT)
Date of Health Assessment:			**Doctors Practice Stamp**
Name of Medical Practitioner:			
Doctors Signature and Practice Stamp: (Including registration number)			
Contact details:			

Assessment results:			
Blood Lead Test	☐	Other (as documented by Doctor)	☐

This section is to be completed by the Occupational Health Nurse/Testing Provider							
This is to certify that: _____ (name) has been drug tested on ____/____/____							
Result		☐ Positive		☐ Negative		☐ Results Pending	
Name:		Signature:		Date:			

Name: _____ Date: _____

Part One (Worker to complete)			
Section 1: Your personal details			
Surname:		First Name:	
Address:		Postcode:	
Home Phone:		Mobile Phone:	
Date of Birth:		Gender:	Male ☐ Female ☐
Family Doctor:		Contact Phone:	
Proposed Employer:		Site Name:	
Proposed Role:		Contact Person:	

(Note – all sections must be complete. If left unmarked, assessment is deemed invalid)

Declaration

I consent to a medical examination, and associated tests to determine the adequacy of my fitness for the work for which I have applied.

I declare that the information, which I have provided in this Medical Assessment, is truthful, and that there are no misleading answers or omissions. I understand that if I am employed and it is subsequently established that I have been misleading or untruthful, my employment may be terminated. I acknowledge that providing misleading or untruthful information may compromise my ability to claim compensation in cases of work-related illness or injury.

I authorise the Appointed Medical Officer to contact any person, clinic or hospital which has previously provided me with treatment in order to obtain further medical information which may assist them or my prospective employer in determining my fitness and suitability for the work for which I have applied.

Name: _____ Signature: _____ Date: _____

Disclosure Consent:

I hereby consent to the release of the record of my medical examination to my employer so it may determine the adequacy of my fitness level for the work for which I have applied.

Name: _____ Signature: _____ Date: _____

Section 2: Your employment history (Please give details of current and previous work positions)

Company	No. of Years	Job Title	Occupational Health Exposures (if any)
1.			
2.			
3.			
4.			

	Yes	No
Do you have a current, or have you ever had a Workers Compensation Claim? If yes, you may be required to provide further information as per section 571D of the Workers Compensation and Rehabilitation Act NT 2015	☐	☐
Details:		

Name: _____ Date: _____

Section 3: Your health history

	Yes	No		Yes	No
1. Are you currently being treated for any medical condition?	☐	☐	2. Have you ever had an x-ray, CT, ultrasound or MRI scan?	☐	☐
3. Is there any history of illness or disease in your family?	☐	☐	4. Have you ever been refused life/disability insurance, military service or employment for medical reasons?	☐	☐
5. Have you ever been admitted to hospital?	☐	☐	6. Have you taken any medications in the last month?	☐	☐
7. Have you ever had a work related illness or injury?	☐	☐	8. Have you visited a therapist e.g. chiropractor, physiotherapist, osteopath etc in the last 2 years?	☐	☐
9. Have you had time off work in the last 2 years for injury or illness?	☐	☐	10. Have you ever been exposed to toxic substances or environmental hazards?	☐	☐
11. Have you ever had trouble wearing (PPE) personal protective equipment (including footwear), safety equipment or breathing apparatus?	☐	☐	12. Are you aware of any condition, injury or illness that may impact on your ability to perform the duties of your job?	☐	☐

If you answer **Yes** to any of the above please provide details:

Doctor to provide comments for any Yes responses: (reference Question No.)

Section 4: Injury and illness history – Have you ever received treatment or medical advice for any of the following?

	Yes	No		Yes	No		Yes	No
13. Lung/Breathing problems	☐	☐	14. Blood pressure/Heart problems	☐	☐	15. Skin disorders/ dermatitis	☐	☐
16. Asthma/Hay fever/Allergies	☐	☐	17. Rheumatic Fever	☐	☐	18. Hernia	☐	☐
19. Arthritis/ Rheumatism	☐	☐	20. Repetitive Strain/ Overuse problems	☐	☐	21. Fits/ seizures/blackouts	☐	☐
22. Anxiety/ Depression	☐	☐	23. Joint problems/fractures/ broken bones	☐	☐	24. Head injury/concussion	☐	☐
25. Other mental health issues	☐	☐	26. Headaches	☐	☐	27. Bruising/ Excessive bleeding	☐	☐
28. Stomach problems/ Ulcers	☐	☐	29. Eye troubles	☐	☐	30. Recent weight loss/gain	☐	☐
31. Liver problems/Hepatitis	☐	☐	32. Back, neck, spinal problems	☐	☐	33. Cancer/other tumour	☐	☐
34. Diabetes	☐	☐	35. Loss of hearing/ Ear infections	☐	☐	36. Clots of legs or lungs	☐	☐
37. Kidney/ Bladder problems	☐	☐	38. Injury from motor vehicle accident	☐	☐	39. Sleep disorders	☐	☐
40. Malaria/ Tropical diseases	☐	☐	41. Sporting injuries	☐	☐	42. Other:	☐	☐

If you answer **Yes** to any of the above please provide details:

Doctor to provide comments for any Yes responses: (reference Question No.)

Name: _____ Date: _____

Section 5: Do you have difficulty with any of the following activities?

	Yes	No		Yes	No		Yes	No
43. Concentrating on a task	☐	☐	44. Standing for 2 hours or more	☐	☐	45. Sitting for 2 hours or more	☐	☐
46. Walking on uneven ground	☐	☐	47. Confined spaces or working at heights	☐	☐	48. Repetitive movement of hands or arms	☐	☐
49. Running 50 metres	☐	☐	50. Climbing stairs/ladders	☐	☐	51. Working in hot/cold extremes	☐	☐
52. Turning your head	☐	☐	53. Using hand tools	☐	☐	54. Shift work/sleep disturbances	☐	☐
55. Crouching/bending/ kneeling	☐	☐	56. Gripping firmly with both hands	☐	☐	57. Understanding English (incl reading signs)	☐	☐

If you answer **Yes** to any of the above please provide details:

Doctor to provide comments for any Yes responses: (reference Question No.)

Section 6: About your lifestyle

	Yes	No		Yes	No
58. Do you engage in regular exercise (30 minutes at least 3 x per week)?	☐	☐	59. Have you ever smoked? (if no, do not answer Q63)	☐	☐
60. Do you take drugs?	☐	☐	If yes, what age did you start? What age did you stop?		
61. Do you drink alcohol? If yes, how many standard drinks do you have per day?	☐	☐	62. Do you smoke?	☐	☐
			If yes, what age did you start? How many per week?		

If you answer **Yes** to any of the above please provide details:

Doctor to provide comments for any Yes responses: (reference Question No.)

Part Two (Assessing Doctor to complete)

Section 7: Measurements

1. Height (cm)		**2.** Weight (kg)		**3.** BMI	
4. Urinalysis	Blood: ☐ N ☐ Abn	Sugar: ☐ N ☐ Abn	Protein: ☐ N ☐ Abn	☐ Referred for review	
5. BSL	mm/L	**6.** Respiratory Rate	/minute	**7.** Reflexes	
8. Blood Pressure	1st reading:		2nd reading:		
9. Pulses	Beats/minute:		Character:		

Section 8: Vision

10. Visual acuity	Near Vision					Distant Vision			
	Uncorrected		Corrected			Uncorrected		Corrected	
Right	N		N		Right	6		6	
Left	N		N		Left	6		6	
Both	N		N		Both	6		6	

Type	Intro	Transformation						Disappearing						Hidden		Diagnostic	
Plate No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Normal Response	12	8	29	5	3	15	74	6	45	5	7	16	73	-	-	26	42
Response	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Colour vision result	Yes	No	**Vision general**	Yes	No
11. Result: / 12 plates	N/A	N/A	**12.** Corrective lenses to be worn at work	☐	☐
13. Colour Ishihara normal	☐	☐	**14.** Peripheral vision R & L normal	☐	☐

Comments:

Name: _____ Date: _____

Section 9: Ears / Nose / Throat / Mouth

	Yes	No		Yes	No
15. Teeth & gums normal	☐	☐	**16.** Throat normal	☐	☐
17. Nose normal	☐	☐	**18.** Ears normal	☐	☐

19. Audiometry ☐ Report attached

	500 Hz	1000 Hz	1500 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz	8000 Hz
Right								
Left								

	Yes	No		Yes	No
20. 16 hours quiet before test	☐	☐	**21.** Ear canals clear	☐	☐
22. Hearing normal	☐	☐	**23.** Not completed due to:		

Comments:

Section 10: Respiratory

	Yes	No		Yes	No
24. Breathing normal and regular in character	☐	☐	**25.** Signs of past/present respiratory disease absent?	☐	☐
26. Auscultation normal	☐	☐	**27.** Spirometry normal	☐	☐

28. Spirometry ☐ Report attached

	Actual		Normal	
FEV1		L/min		%
FVC		L/min		%
FEV1 / FVC		%		
VO2 Max				%

Comments:

Name: _____ Date: _____

Section 11: Cardiovascular

	Yes	No		Yes	No
29. Blood pressure normal	☐	☐	**30.** Veins and other vessels normal	☐	☐
31. Pulse normal	☐	☐	**32.** Peripheral pulses normal	☐	☐
33. Heart sounds normal	☐	☐		☐	☐

Comments:

Section 12: Musculoskeletal system

Range of movement normal for:

	Yes	No		Yes	No		Yes	No
34. Hands	☐	☐	**35.** Feet	☐	☐	**36.** Cervical spine	☐	☐
37. Wrists	☐	☐	**38.** Ankles	☐	☐	**39.** Thoracic spine	☐	☐
40. Elbows	☐	☐	**41.** Knees	☐	☐	**42.** Lumbar spine	☐	☐
43. Shoulders	☐	☐	**44.** Hips	☐	☐	**45.** Duck Walk Test	☐	☐
46. Biering Sorensen Test	☐	☐	Findings:					
47. Job Task Evaluation	☐	☐	☐ Report attached					
48. Posture	☐ Good		☐ Average			☐ Poor		

Comments:

Medical Provider Sign Off

Name of Medical Practitioner:		
Comments on Part 1 and / or Part 2:	**Q No.**	**Comment**
Doctors Signature, contact details and Stamp (including registration number)		**Doctors Practice Stamp**

NOTE 1: Any errors, corrections or changes require the assessing Doctors initial and date beside the amendment.

Appendix B: Contractor Health Declaration

Contracting Company:

Date:

RE: Health Declaration

Email delivered to: MRMmedical@glencore.com.au

I …… (Must be superintendent/ manager of employing company) do solemnly and sincerely declare that:

Name :	
Date of Birth :	
Date of Medical :	(must be within 12 months)

Is fit for their position, and has no significant health concerns, injuries or medical conditions since completing their medical.

Regards,

Signature of declarant/deponent:

Position title:

Appendix C: Medical Information Form

McArthur River Mining
Medical Information Form

Information supplied on this document remains confidential and is used only by the Medical Centre staff for Medical reference.

Please complete all sections of this form

Personal Details

SURNAME:		Given names:		MRM Pay N°	
Date of Birth:		Home Phone:		Mobile:	
Address:			State:	Post Code:	
Postal:			State:	Post Code:	
After Hours Site Contact Number (If App)			Gender:	Male ☐	Female ☐

Employment details

Permanent MRM Employee ☐	Long Term Contractor ☐	Short Term Contractor ☐	Site Visitor ☐
Date Commenced On Site:		Date to end employment on site (visitors and short term employees):	
Company Name:		Job Title:	
Site contact/ Supervisor:		Site Contact Phone N°:	
Responsible Department:		Work Area:	
Roster:			

Medical History (Please tick appropriate box)

Sinusitis	☐	High Blood Pressure	☐	Hayfever	☐
Fainting	☐	Asthma	☐	Headaches	☐
Stomach Trouble	☐	Dermatitis	☐	Migraines	☐
Hernias	☐	Gout	☐	Heart Conditions	☐
Arthritis	☐	Hearing Loss	☐	Back Pain	☐
Visual Aids	☐	Glandular Problems	☐	Diabetes	☐
Other (Please Give Details):					

Immunisation History

ADT (Tetanus)	Yes ☐	No ☐	Dates:	
Hepatitis A	Yes ☐	No ☐	Dates:	
Hepatitis B	Yes ☐	No ☐	Dates:	
Other (Give Details):				

Other Relevant Information or Comments

Are you currently taking any medication? No ☐	Yes ☐	Give details:	
Current First Aid Qualifications:		Expiry date:	
Height:		Weight:	
Are you allergic to anything?	No ☐	Yes ☐	Give details:
Smoker: No ☐	Yes ☐	If yes, how many cigarettes per day:	

Next of Kin

Name:			Relationship		
Telephone:	Work:		Home:	Mobile:	
Address (If Different):					

In case of falling ill while on site; and requiring paramedic or medical attention, I authorise the Paramedic/Medic to provide a brief summary of my medical condition to my supervisor upon request.	Yes ☐	No ☐
In the case of being Injured or Fall ill at work, I consent to the information on this form being released to the receiving Hospital, treating Doctor and/or Paramedic, who may be required to treat or transport you.	Yes ☐	No ☐
Signature:	**Date:**	

9 ACKNOWLEDGEMENT

Acknowledgment of MRM Medical Assessment Procedure

STATEMENT: I, _____ (PLEASE PRINT YOUR FULL NAME)

Hereby acknowledge that I have been presented and understand the above information and through my signature below I agree to observe the safety rules and requirements of this procedure and statutory requirements applicable to the company's operations.

(Please tick the following if correct)

☐ I have listened to or read all the information.

☐ I have referred any matters requiring explanation to my supervisor/trainer

☐ I thoroughly understand all the information.

I accept that my adherence to these rules and requirements are a condition of my continuing employment at this site.

Signature: _____ **Date:** _____

Trainers Name: _____

Trainers Signature: _____ **Date:** _____