Mines and Energy

Coal Mine Workers' Health Scheme

Approved Form - Section 4 – Health Assessment Report

Coal Mine Worker's Details

Family Name	Given Name(s)	Date of Birth

Employer	Mine(s) (if applicable)

Examination Details

Date of Examination by EMO	Position (e.g. job title (generic)	Is the assessment for underground work? Yes	No
			X

As at the date of this examination, the coal mine worker:

	Is fit to undertake any position	☐ Is suitable for and has no condition which precludes participation in mines rescue - See Mines Rescue Medical Guidelines For Queensland Mines Rescue Service personnel / applicants only.
	Is fit to undertake the proposed / current position	
X	Is fit to undertake the proposed / current position subject to the following restriction(s) (if necessary, outline a management program)	
X	**Corrective lenses required for near vision**	
X	***Negative drug and alcohol screen result dated:***	
	Is not fit to undertake the proposed / current position because of the following	
	restriction(s):	

The duration of the restriction is:

Is a further review necessary?	Yes		Date	No	X	
Specify full or type of review required:						
Was a chest x-ray taken?	Yes	X	Date	No		
As Nominated Medical Adviser I have explained the restriction / additional assessment to the worker				Yes	X	No
As Nominated Medical Adviser I have provided a copy of Section 4 to the worker (refer Note a):				Yes	X	

I have been advised of the outcome of this assessment. (Practical constraints prevent this from being a compulsory item)	Coal Mine Worker's Signature:	Date
Nominated Medical Adviser's name and address:	NMA's Signature:	Date

Distribution:

a) copy of Section 4 to coal mine worker at address shown on page 2; and
b) copy of Section 4 to employer; or in the case of Mines Rescue membership a copy also to Queensland Mines Rescue Service, GPO Box 156, Dysart, QLD 4745; and
c) copy of complete Health Assessment Form to Health Surveillance Unit, Safety & Health, Mines & Energy, PO Box 15216, City East 4002.

MEDICAL MANAGEMENT PLAN

This document must be filled in by contractors or employees who have been identified as having restrictions on their Coal Board Medical.

Please complete the relevant sections of this form and attach additional information (such as specialist reports) if required or as requested by Millennium Mine Health, Safety, Environment and Training Department staff.

Name		**Date of Birth**	
Company		**Job Role**	

I am aware of the following restriction(s) listed on Section 4 of my Coal Board Medical. My employer is also aware of the restriction(s):

Tick Applicable	Restriction
☐	Adherence to hearing protection protocols
☑	Use of corrective lenses
☐	Diabetes (Type I or II)
☐	Weight restrictions for operating equipment
☐	Colour discrimination
☐	Confined space restriction
☐	Other - Specify:

While working at Millennium Mine, I will personally and adequately manage any and all restriction(s) with the following control(s):

Tick Applicable	Restriction
☐	Using hearing protection at all times in the work environment
☐	Adhering to PPE requirements
☐	Using declared medications to manage my condition
☑	Using corrective lenses where necessary
☐	Notifying my supervisor of my restrictions and any concerns I may have
☐	Check weight restrictions on equipment seating prior to operating equipment
☐	Other – Specify or attach management plan :

I am aware of the following requested medical review(s) in the next 12 months

☐	Audiology Review	☐	BP Check	☐	Specialist review
☐	Spirometry	☐	Weight Review	☐	Other medical review/test

Employee/Contractor

Name:	**Company:**
Signature:	**Date:**

Contract Company Supervisor/Representative

Name:	**Company:**
Signature:	**Date:**

Peabody Dept. Manager/Superintendent Acknowledgement

Name:	**Date:**
Signature:	