So that we can manage your work activities properly;

Do you have any health complaints, illnesses or injuries that may affect your ability to undertake survey tasks? Or which may be worsened or aggravated by certain tasks? (Please provide further details over page if required)

Are you on any medication that may impair your ability to perform your work activities. An example of medications that can cause impairment is available at <https://www.vicroads.vic.gov.au/safety-and-road-rules/driver-safety/drugs-and-alcohol/medicines-and-road-safety> and <https://www.health.nsw.gov.au/aod/resources/Pages/driving-safety-medicines.aspx>

Are you on any medications that may be detected on a random drug test? Examples: Librium, Transene, Valium, Rohypnol, Mogodon, Serepax, Seconal. Please refer to the Austraffic Drug and Alcohol Procedure.

**If you answered yes to any of the above,** please take this form with you to your prescribing doctor and/or pharmacist and take care to clearly explain your duties as employed by Austraffic, in order to establish fitness for work.

**I would like to declare the following medication and prescribed amount:**

|  |  |  |
| --- | --- | --- |
| Medication name / purpose | Prescribed amount | Prescribing doctor |
|  |  |  |
|  |  |  |
|  |  |  |

If more space required please write on a separate sheet of paper and attach to this form

* I am fit to work and can perform all duties expected of me to a safe standard.
* Else, where there is an exception to the above, I have attached a signed letter from my doctor detailing my limitations.
* For over the counter medication I have carefully read all instructions and taken the medication as directed (e.g. if advised not to operate heavy machinery this will be followed).

|  |  |  |
| --- | --- | --- |
| **My Name** |  | |
| **My Signature & Date** |  | |
| **Only required if you answered ‘yes’ to any of the questions above** | | |
| **Doctor/Pharmacist Name** | |  |
| **Doctor/Pharmacist Signature & Date** | |  |

|  |  |
| --- | --- |
| **Admin / Management Review** | |
| Employee Name |  |
| Is a Doctor/Pharmacist sign off required? |  |
| If yes, has this been obtained? |  |
| Is further information/action required? |  |
| Reviewed By: |  |
| Date: |  |