This document must be filled in by the employee who has been identified as having restrictions on their Rail Safety Worker Medical.

Please complete the relevant sections of this form and attach additional information (*such as specialist reports or GP health plan*) if required or as directed by Martinus Health and Safety staff.

**Worker Information:**

|  |  |
| --- | --- |
| Surname: | Given Name(s): |
| Date of Birth: | Job Role: |
| RIW Number: | Company: |

**I am aware of the following restriction(s) listed on the *Part-B Health Assessment Report Form* or the *Part-B Triggered Health Assessment Report Form*.**

**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) – *Always make sure your sharps are secured and disposed of in a strong plastic container* |
|  | Weight restrictions for operating equipment |
|  | Colour discrimination |
|  | *Other* – Specify: (Define): |
|  | *Other* – Specify: (Define): |

**While working on a Martinus site, 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 |
|  | *Bring with me and carry surfactant medications to match my roster with me* |
|  | 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: (Define) |
|  | *Other* – Specify or attach management plan: (Define) |

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | *Audiology Review* |  | *BP Check / Review* |  | *Specialist Review* |
|  | *Spirometry Review* |  | *Weight Review* |  | *Other* - Medical Review / Testing |
|  | *Other Triggered Review* | (Define): | | | |

**Worker/Contractor:**

|  |  |
| --- | --- |
| Name: | Name: |
| Signature: | Date: |

**Employer – Senior Representative:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | Name: | | |
| Signature: | Date: | | |
| Position: |  |  |  |

**Martinus – Management Review:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | Name: | | |
| Signature: | Date: | | |
| Position: | **Outcome** | Procced | **Hold** |

**DISCLAIMER:** This assessment does not provide advice on a particular matter, nor does it substitute for advice from an appropriately qualified medical professional. No warranty of safety should result from its use. The screening system in no way guarantees against injury or death. No responsibility or liability whatsoever can be accepted by Martinus for any loss, damage or injury that may arise from any person acting on any statement or information contained in this tool.