HUMBERMED LIMITED

Occupational Health Consent Form

SECTION 1

Company/Organisation ..... Job Title .....

Surname ..... Forenames .....

Address ....

Post Code ..... Contact Number .....

Mr/Mrs/Miss/Ms/Title ..... DOB: ☐☐ ☐☐ ☐☐☐☐

Email Address .....

DATA PROTECTION

You are asked to complete this form in order to provide a medical view of your fitness for employment or specific task. Without this information your application/assessment of fitness will not be able to proceed further. The Occupational Health Medical Adviser may require further information about your health before being able to come to a view on your fitness. Your consent to further reports from your medical advisers will be sought in these circumstances before a certificate of fitness/restrictions/unfitness can be issued. All such medical information will be kept in strict medical confidence by the OH staff and processed in accordance with our Privacy Policy available at humbermed.co.uk.

SECTION 2 - Medical Assessment carried out

Clinical Examination	☐	**Vision Screening**	☐
Respiratory Function	☐	**Alcohol Breath or Saliva Testing**	☐
ECG Testing	☐	**Urine Drug Testing**	☐
Hearing Test (Audiometry)	☐	**DVLA D4 Medical (LGV / PCV)**	☐
Skin Assessment	☐	**OEUK / HSE Dive Medical**	☐

Other (specify) .....

SECTION 3 - CONSENT & DECLARATION

I confirm that the nature and purpose of the assessment has been explained to me. I understand that the results of the assessment will be used to provide both my employers or prospective employer and myself with advice regarding my fitness for work. I am aware of the Employer's policy for a positive Drug or Alcohol Result and accept the technician's / clinician's interpretation of the result. Only relevant medical information will be provided to my employers. I consent to medical information being forwarded to my general practitioner or other medical specialists if deemed necessary.

I agree to my personal data and medical records being stored, processed and transferred electronically, securely and confidentially by Humbermed Limited in accordance with the Privacy Policy available at Humbermed.co.uk.

I declare that the information given by me is true and accurate to the best of my belief and knowledge.

Signature ..... ***Date*** .....

Humbermed Ltd

OFFSHORE ENERGIES UK - OEUK Medical QUESTIONNAIRE / EXAMINATION FORM

Personal Details:			**Date of examination:**
Surname:		**Forename:**	
Address:			**Date of birth:**
			Tel no:
Occupational Details:			
Employer name:		Job title.	
Duration: in current job:	With current employer:		Date of next trip:
Sector: *(circle which applies)*	UK only Worldwide	**Type of employment**	Core crew Ad hoc crew
Job involves *(circle which applies)*	Food handling Operating a crane ERT duties (Emergency Response Team) Work on NUI (normally unmanned installations)		
Types of occupations prior to working offshore:			
(details)			
Date/provider of most recent:	OEUK Medical: ….....	EBS - Fit to train assessment: ….....	Next - FOET / BOSIET training: ….....
Any restrictions/time limits placed on your last OEUK cerificate?		YES NO Details	
Health habits:			
Smoking: *(circle which applies)*	Never smoked Ex-smoker Vape only Current Smoker Both Smoke & Vape		
Average alcohol intake: (units per week)	*1 unit = approx 1/2 pint of standard strength lager/bitter, single 25 ml measure of spirits, small glass (125ml) of wine*		
(circle which applies)	0-14 15-28 29-56 57+		
Physical activity levels:			
Do you undertake an average of at least 20-30 minutes of exercise / day? (can include moderately strenuous work activity - eg steps)			
YES (circle which applies) NO			
Advice offered by practitioner re safe alcohol intake, exercise and smoking cessation (as relevant)		*Yes*	*No*
Medical History			
Condition / Question		(circle which applies)	Details
Have you experienced any occupational conditions (e.g. Asthma, skin conditions), job loss for medical reasons, Medevac/missed trip history?		Yes No	
Current medical history (general) – presence of any ongoing medical diagnosis or undiagnosed symptoms (whether treated or not)			
Any current / intended periodic appointments at GP/Primary Care Physician, and/or hospital clinic for any medical condition (and whether attended as intended)		Yes No	
Name of any current medications (please include dose and indication)		Yes No	
Notes:			

This section is about previous attendance at hospital clinics (outpatient clinics – ambulatory care) or past admissions to hospital for any operations illnesses, investigations, or tests.

Are you currently or have you previously been diagnosed with:		**Please provide full details including dates**
1) Raised blood pressure, any type of cardiovascular or cerebrovascular disease, (including Angina, heart attack, Stroke, RIND or TIA (temporary Stroke or Nerological loss) or Congenital heart disease?	Yes No	
2) Seizure disorders (eg Epilepsy), loss of consciousness episodes, other chronic Neurological disorders, (e.g. Multiple Sclerosis, Parkinson's Disease) or severe / recurrent Migraine or dizziness	Yes No	
3) Anxiety – Depression, Psychotic illness, Neurodevelopmental disorders (e.g., ADHD, Autism), alcohol use disorder, substance, misuse, use of "recreational" drugs or claustrophobia/flying phobia	Yes No	
4) Asthma (including Occupational), COPD, Pneumothorax, excess breathlessness (eg on moderate exertion) or chronic cough	Yes No	
5) Diabetes, thyroid disorder, Addison's disease,	Yes No	
6) Peptic ulcer, Inflammatory Bowel Disease (e.g. Crohn's/Ulcerative Colitis), Pancreatitis, liver disease, Hernia	Yes No	
7) Limb amputation, Arthritis, joint replacement, frequent or persisting muscular pain (including back pain) causing functional impairment.	Yes No	
8) Eczema / Dermatitis, (including work-related), Psoriasis	Yes No	
9) Kidney disease, stones or blood in the urine	Yes No	
10) Bleeding disorder, clotting disorder, Sickle Cell disease	Yes No	
11) Organ transplant	Yes No	
12) Cancer	Yes No	
13) Infectious diseases – Tuberculosis, HIV, Hepatitis	Yes No	
14) Hearing loss, dizziness – vertigo, perforation of Tympanic membrane	Yes No	
15) Visual loss or impairment, visual field loss, double vision	Yes No	
16) Conditions causing immune deficiency, use of immunosuppressant medication.	Yes No	
17) Untreated Dental carries (tooth or gum disaese)	Yes No	
18) Allergic disorders (including food allergy) Anaphylaxis.	Yes No	
19) Current pregnancy	Yes No	
20) Self perception of disability or classification as disabled by any insurer or benefits scheme.	Yes No	

Notes:

CONSENT & DECLARATION

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I declare that the information given by me is true and accurate to the best of my belief and knowledge.

Signature: Date: