

## Fitness to Work Certificate for drivers

Employee Data		Date <u>14/3/23</u>																						
Name <u>CHAMKOR SINGH</u>		Department/Company <u>Reckonw</u>																						
I.D No. <u>90477852</u>	Age <u>35</u>	Occupation <u>H.D.</u>																						
Type of Medical Evaluation		Mark those applying																						
<input checked="" type="checkbox"/> A6- HVD- Crane or forklift driving & all heavy vehicles		<input checked="" type="checkbox"/> A7- Professional driving-light vehicles																						
<p><b>Health Advisor Statement:</b> The above named person has been examined according to the statements laid down in "Protocols and Guidance Notes on the Medical Evaluation of Fitness to Work". At this time his/her fitness to work status for the above tasks is as follows.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">Fit with no restrictions</td> <td style="width: 50%; padding: 5px;">✓</td> </tr> <tr> <td colspan="2" style="padding: 5px;">Fit with following restriction(s)</td> </tr> <tr> <td style="padding: 5px;">The employee is fit for above work but should avoid the following task(s)</td> <td style="padding: 5px;">Temporary restriction</td> <td style="padding: 5px;">Permanent restriction</td> </tr> <tr> <td style="padding: 5px;">Work near moving machinery or sharp edges</td> <td style="padding: 5px;">✓</td> <td style="padding: 5px;">✓</td> </tr> <tr> <td style="padding: 5px;">Operate Heavy motor vehicles, forklifts or heavy machinery</td> <td style="padding: 5px;">✓</td> <td style="padding: 5px;">✓</td> </tr> <tr> <td style="padding: 5px;">Other (Specify)</td> <td style="padding: 5px;">✓</td> <td style="padding: 5px;">✓</td> </tr> <tr> <td colspan="3" style="padding: 5px;">Temporary Unfit until</td> </tr> <tr> <td colspan="3" style="padding: 5px;">Permanently Unfit</td> </tr> </table>			Fit with no restrictions	✓	Fit with following restriction(s)		The employee is fit for above work but should avoid the following task(s)	Temporary restriction	Permanent restriction	Work near moving machinery or sharp edges	✓	✓	Operate Heavy motor vehicles, forklifts or heavy machinery	✓	✓	Other (Specify)	✓	✓	Temporary Unfit until			Permanently Unfit		
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Name of health advisor <u>CHAMKOR SINGH</u> Signature <u>DR. CHIEMEKA NDUKA ENACHE</u> Date <u>14/3/23</u>																								





## 11.20 Appendix 20: (Form SQ5): Epworth Screening Quest. for Sleep Apnoea

Employee Data	Date: 14/3/23
Name: Ct Ankur SINGH	Department/Company: TRUCKMAN
I. D No. 90471862	Occupation: H.D
Tel # 7844848	

This questionnaire will help identify if you have any health condition which may need a more detailed medical assessment as part of your fitness to work determination. If you have any queries please contact your local Health Services staff. All information provided on this form and during consultations remains strictly confidential. When further clinical evaluation is required following completion of a screening questionnaire, the details should be recorded on Q1 and E1 forms.

How likely are you to fall asleep in the following situations? (use 0 to 3 score as shown below)

- 0 Would never doze
- 1 Slight chance of dozing
- 2 Moderate chance of dozing
- 3 High chance of dozing

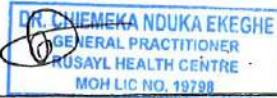
<input checked="" type="radio"/>	sitting and reading
<input checked="" type="radio"/>	watching TV
<input checked="" type="radio"/>	sitting inactive in a public place (e.g. theatre or meeting)
<input checked="" type="radio"/>	as a passenger in the car for an hour without a break
<input checked="" type="radio"/>	Lying down to rest in the afternoon when circumstances permit
<input checked="" type="radio"/>	Sitting and talking with someone
<input checked="" type="radio"/>	Sitting quietly after lunch without alcohol
<input checked="" type="radio"/>	In a car, while stopped for a few minutes in traffic
Total <input type="text"/>	

If you score a total of 15 or more you should seek advice from medical personnel on site before continuing to drive or operate machinery in the workplace.

Declaration: I, Ct Ankur Singh (Print Name) certify that to the best of my knowledge the above information supplied by me is true and correct.

Signature: 

Date: 14/3/23



ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE  
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/Forenames	CHANKOR SINGH KIRPAL
Nationality	INDIAN

Mobile No. 7844818 Home/Leave Address:

Company Number:

Reference Indicator:

Personal Details

35

A  Male  Female

Married  Single  Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee

Wife  Son  Daughter

No of Children: 2

Reason for Examination (tick as appropriate)

Periodic Medical Examination

Final / Retirement

Other Reason:

Employee only

B Present Job and Location:

HRD

Next Job and Location:

Are you a registered person with special needs?

Do you belong to any Medical Insurance Scheme?

**Previous Medical History:** All important medical events should be listed and dated at every medical examination. To be completed together with the interviewing Nurses or Doctor who will be able to help by referring to your notes.

Please answer the following questions and tick 'N' (no) or 'Y' (yes) in the column. If 'Y' Please describe

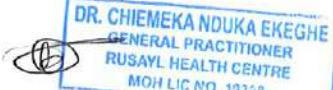
	N	Y	Description
Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?			
1 Ear, nose, eye or throat problems		✓	
2 Chest problems like asthma, bronchitis, other bad cough		✓	
3 Heart abnormality, chest pains		✓	
4 Abdominal pains, abnormal bowel motions		✓	
5 Urogenital problems (kidney disease, menstrual disorder)		✓	
6 Skin trouble or allergies		✓	
7 Epileptic fits, dizzy spells or migraine		✓	
8 History of mental illness, depression anxiety		✓	
9 Diabetes, thyroid disease		✓	
10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia		✓	
11 Any history of accidents or fractures		✓	
12 Have you had any serious allergies		✓	
13 Do any dependants have a significant ongoing illness?		✓	
14 Any family history of cancers		✓	
Do you take any regular medicines, or have you taken in the past?		✓	
Do you smoke? If yes, what and how much each day?		✓	
Do you drink alcohol? If yes, what is your average weekly intake?		✓	
Have you ever taken elicited/recreational drugs?		✓	
Are you doing regular sports or physical activities?		✓	

**STATEMENT:** I have read the above questions and the above answers are correct and no information concerning my present or past state of health has been withheld. I understand and agree that this form will be held as a confidential record by PDO Medical Department, and may be copied (by paper or secure electronic transmission) to the Occupational Health Services for the purpose of Health Surveillance and other Occupational Health review.

Date:

14/3/23

Signature of Applicant:



FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

N = Normal A = Abnormal (please describe)

PHYSICAL EXAMINATION

N	A	
✓		1. Eyes & Pupils
✓		2. E.N.T.
✓		3. Teeth & Mouth
✓		4. Lungs & Chest
✓		5. Cardiovascular System
✓		6. Abdo. Viscera
✓		7. Hernial Orifices
✓		8. Anus & Rectum
✓		9. Genito-urinary
✓		10. Extremities
✓		11. Musculo-skeletal
✓		12. Skin & Varicose Vns.
✓		13. C.N.S.

HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE /mins.	HEARING L R R N	DISTANT R L	VISION NEAR R L
170	94.9	32.8	120/70	78	Uncorrected Corrected	1/1/1/1	1/1/1/1

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
✓		1. Urinalysis		7. Audiogram
✓		2. Hb, Bloodcount, ESR		8. Lung Function
✓		3. LFT RFT, RBS		9. Chest X-Ray
✓		4. Drug Screen		10. ECG
✓		5. Lipids (40 years +)		11. CVS risk for 40 yrs. & above
✓		6. Sickle Cell test		12. HIV, Hepatitis screening

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

elevated Liver enzymes



ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS

FIT WITH RESTRICTION

TEMPORARY UNFIT

UNFIT

Fit to work as long as he's taking

medication

Date: 14/3/28

Name (Block Capitals): Dr. / Nurse

CHIEMEKA EKECHI

Signature:

REVIEW/CONSULTATION

Regular exercise  
LIV S2 B2 8/12  
repeat LFT in 3 months

Date: 14/3/28

Name (Block Capitals): Dr. / Nurse

CHIEMEKA EKECHI

Signature:

