|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last Name: First Name: Date of Birth: MM/DD/YYYY  Tel phone number: ( ) - Company: | | | | |
| SECTION 1: MEDICAL INFORMATION | | | | |
| The purpose of this medical declaration is to identify, and safely manage, any medications or health conditions that may put you at risk while undertaking critical, safety-sensitive work. This disclosure is CONFIDENTIAL. Only the Health Contact (Medic, Houston Health Services RN, Petroleum or Local Medical Director) will have access to this information. This form will be stored in the Petroleum Deepwater (WEL) secure Cority system. The Health Contact may discuss any concerns identified with you. | | | | |
| Please answer the questions below by checking YES or NO | YES | | NO | |
| 1. Do you have any condition/s that may prevent or affect you from doing the tasks or meeting the physical demands required of your role? |  | |  | |
| 1. Do you have any condition/s that may prevent or affect you from meeting the environmental conditions of your role (e.g., outdoors, shift work, work at heights, confined spaces, underground)? |  | |  | |
| 1. Do you have any conditions that may prevent or affect you from wearing any standard or specialised PPE required for your role (e.g., respirator, hearing protection, fall protection equipment, welding visors)? |  | |  | |
| 1. Do you have any pre-existing injuries or illnesses which may be aggravated either by being on the job site or by performing your usual work duties? |  | |  | |
| 1. Are you, or have, you experienced any of the following conditions? |  | |  | |
| 1. High or low blood pressure |  | |  | |
| 1. Epilepsy or seizures |  | |  | |
| 1. Heart disease (e.g., angina), chest pains, or irregular heartbeat. |  | |  | |
| 1. Vision problems (excluding those corrected with glasses) or hearing problems |  | |  | |
| 1. Dizziness, fainting, vertigo, or problems with balance |  | |  | |
| 1. Diabetes or indications of diabetes (e.g., high or low blood sugar levels) |  | |  | |
| 1. Frequent headaches or migraines |  | |  | |
| 1. Allergies (Bee stings, Hay fever, Medications) |  | |  | |
| 1. Shortness of breath, wheeziness, or asthma |  | |  | |
| 1. Heat Illness |  | |  | |
| 1. Head, back, or neck injury/pain/condition (including intermittent or regular chiropractic or physiotherapy) |  | |  | |
| 1. Pain, swelling or numbness in the joints (knees, hips, shoulders, wrists) |  | |  | |
| 1. Have you ever undergone surgery for a sport or work-related injury |  | |  | |
| 1. Skin rashes or conditions (e.g., dermatitis, eczema) |  | |  | |
| 1. Sleep apnea or use of a CPAP machine |  | |  | |
| 1. Are you presently taking any prescription or over-the-counter medications/supplements (including insulin or CBD) |  | |  | |
| If you answered YES to any of the above, please provide a short explanation including details on any restrictions. For medications, please indicate the name, dosage and reason for taking. | | | | |
| If you would like to speak to a health care professional about any other condition you may be suffering, please contact your PET Health Contact to make arrangements. | | | | |
| SECTION 2: APPROVAL TO RELEASE INFORMATION | | YES | | NO |
| I consent to release this information to the PET Health Contact (only) for evaluation of any conditions that may affect my ability to safely conduct my work. | |  | |  |
| Signature: Printed Name: | | Date: | | |