

Fatigue Risk Self-Assessment

Personal Details

Employee Name*: _____
Job Title / Position: _____
Date of Assessment*: _____
Current Shift Type*: _____ > Options: Day, Afternoon, Night, Rotating, Other

Fatigue Factors

Total Hours Slept (last 24 hrs)*: _____
Total Hours Slept (last 48 hrs)*: _____
Consecutive Days Worked*: _____
Self-Rated Fatigue Level (1=Not fatigued, 5=Extremely fatigued)*: _____ > Options: 1, 2, 3, 4, 5
Describe any fatigue-related symptoms: _____

Risk Controls

Do you feel fit for duty?*: _____ > Options: Yes, No
Actions taken if not fit for duty (e.g., notify supervisor, rest): (Fill only if applicable)

Will you operate vehicles or plant today?*: _____ > Options: Yes, No
Control measures to manage fatigue (e.g., breaks, job rotation): (Fill only if applicable)

Confirmation

Employee Signature*: _____ (Sign above)

Supervisor/Reviewer Signature: _____ (Sign above)