

Fitness for Work Declaration

Worker Details

Full Name*: _____

Employee ID*: _____

Position / Role: _____

Department: _____

Date*: _____

Worker Signature*: _____ (Sign above)

Self-Assessment

Have you had adequate sleep (minimum 7 hours) in the last 24 hours?*

_____ > Options: Yes, No

If no, provide details: (Fill only if applicable)

Have you consumed alcohol or recreational drugs in the last 12 hours?*

_____ > Options: Yes, No

If yes, provide details: (Fill only if applicable)

Are you taking any medication that could affect your ability to work safely?*

_____ > Options: Yes, No

If yes, list medications: (Fill only if applicable)

Do you have any illness or injury that could affect your work today?*

_____ > Options: Yes, No

If yes, provide details: (Fill only if applicable)

Are you experiencing stress or fatigue that may impact your performance?*

_____ > Options: Yes, No

If yes, provide details: (Fill only if applicable)

Based on the above, are you fit for work?*: _____ > Options: Yes, No

If no, explain: (Fill only if applicable)

