

Health Surveillance Consent

Personal Details

Full Name*: _____

Employee ID*: _____

Date of Birth*: _____

Position/Job Title: _____

Department: _____

Email: _____

Phone Number: _____

Surveillance Details

Type of Health Surveillance: _____ > Options: Audiometric Testing, Respiratory Function Testing, Biological Monitoring, Vision Testing, Other

Reason / Exposure Details*: _____

Next Surveillance Date: _____

Consent

- I consent to participate in the health surveillance program*
- I consent to my surveillance results being shared with my employer's WHS team

If you do not consent, please state your reason: *(Fill only if applicable)*

Occupational Health Provider

Medical Practitioner / Provider Name*: _____

Provider Address: _____

Provider Phone: _____

Provider Email: _____

Signatures

Employee Signature*: _____ (Sign above)

Date Signed by Employee*: _____