**MEDICAL IN CONFIDENCE**

|  |  |
| --- | --- |
| **Full Name** |  |
| **Job Title** |  |
| **Date of Review** |  |

|  |  |  |
| --- | --- | --- |
| **Questions** | | **If YES, please give further details** |
| **Have you come into contact with any of the following substances in the last six months** | **Yes / No** | **Please detail the approximate hourly exposure each day** |
| Cement |  |  |
| Oils/Fuels |  |  |
| Adhesives |  |  |
| Grout |  |  |
| Silicon |  |  |
| Paint |  |  |
| Cleaning Agents |  |  |

**If YES to any of the above, please complete the next section.**

|  |  |  |
| --- | --- | --- |
| **Questions** | | **If YES, please detail (including duration)** |
| **Have you suffered from any of the following in the last six months:** | **Yes / No** |
| Redness of the skin |  |  |
| Itching and burning of the skin |  |  |
| Weeping and crusting of the skin |  |  |
| Blisters |  |  |
| Have you received any Occupational Dermatitis awareness training in the past 6 months? |  | **If YES, please give details** |

|  |  |  |  |
| --- | --- | --- | --- |
| **I understand that I may be required to attend a medical with a doctor appointed by the Company.**  **I give permission for the Company to approach my doctor concerning my medical history.**  **The answers given in this questionnaire are true and comprehensive.** | | | |
| **Signed:** |  | **Dated:** |  |
| **Reviewed:** |  | **Dated:** |  |
| **Comments:** |  | | |