

SITE ACCESS PERSONAL MEDICAL DETAILS FORM

PERSONAL DETAILS			
Surname:		Given Name:	
Employer (Company Name in Full):			
Role on Site:			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		DOB:	
Street Address:		Suburb:	Postcode:
Phone	Home:	Mobile:	
Email Address:			
Site:			
<p>a) You are advised that if you fail to disclose on this form any relevant information relating to your ability to, and ability to safely, fulfil the inherent requirements of the role you are returning to after prolonged absence from the workplace, your employment may be terminated or a future claim for workers' compensation may be denied.</p> <p>b) Please be aware that any personal, health and medical information that you provide to Northern Star medical services suppliers, medics, or other OHS personnel before and during employment with Northern Star are medical records which are the property of Northern Star.</p> <p>c) Information about the privacy of your health and medical information is provided at the end of this form.</p> <p>d) I acknowledge my health and medical information provided to Northern Star before and during employment are the property of Northern Star.</p> <p>e) I consent to clarification of medical information with my treating medical practitioner if necessary.</p> <p>f) I acknowledge results will be received by Northern Star or an authorised representative.</p> <p>g) I have answered all questions (including questions on any signed supplementary forms) honestly, correctly and completely.</p> <p>h) I have not knowingly withheld any relevant information.</p> <p>i) I understand that incorrect or misleading statements or omissions may:</p> <ul style="list-style-type: none"> i. result in the termination of any employment by Northern Star; ii. negate any future claim for compensable injury/illness. <p>By signing below, I acknowledge and agree to the above.</p>			
Signature: _____		Date: _____	
MEDICAL DETAILS			
Current/Ongoing Medical Conditions:			
Is there any other medical condition or information you would like to disclose?			
Allergies:			
Allergies to Medications:			
Current weight:			
REGULAR DOCTOR			
Name:		Practice Location:	Phone:

Prepared by:	Hannah Riley	Document Status:	Controlled
Approved by:	Group Manager - Health & Safety	Review Date:	25/08/2027
		Approver's Signature:	Ian Warman

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MEDICATION DETAILS

I declare that I am currently taking the following prescribed or over the counter medication:

Medication Name	Prescribed by Doctor (Y/N)	Dosage & start date	Reason for use

This questionnaire must be completed in order to help assess your ability to, and ability to safely, fulfil the inherent requirements of the role you are returning to after prolonged absence away from the workplace. Please answer the questions honestly and accurately by ticking the appropriate box or circling the appropriate response. If you are not sure, leave the question blank. Where you answer "yes", please provide details in the space provided. Northern Star's doctors will review your responses:

		YES (provide details)	NO	DETAILS (include dates, ongoing condition management and emergency considerations):
1.	Are you currently being treated by any doctor for any illness/injury?			
2.	Have you had an operation in the past 12 months?			
3.	Do you have previous injuries or illness that cause/may cause aggravation?			
4.	Have you ever been immunised against tetanus?			
5.	Do you, or have you <u>ever</u> , suffered from:			
	(a) Tuberculosis			
	(b) Wheezing/Bronchitis/Asthma			
	(c) Diabetes (indicate Type 1 or Type 2)			
	(d) Abnormal blood pressure			
	(e) Heart disease/condition			
	(f) Stomach conditions or Ulcers			
	(g) Excessive noise exposure/loss of hearing			
	(h) Skin disorders/Dermatitis			
	(i) Chronic ear conditions/Tinnitus			
	(j) Seizures/blackouts or dizziness			
	(k) Head injury/concussion			
	(l) Hernia			
	(m) Eyesight disorders/colour blindness			
	(n) Olfactory impairment (sense of smell)			
	(o) Blood disorders			
	(p) Anxiety / Depression			
	(q) Thyroid or hormone condition			
	(r) Sleep disorder - insomnia			

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		YES (provide details)	NO	DETAILS (include dates, ongoing condition management and emergency considerations):
6.	Have you ever been diagnosed with a neurological condition, such as ADHD or Autism.			
7.	Do you have any phobias (e.g. fear of heights, confined spaces etc)			
8.	Do you have, or have you ever suffered an injury to:			
	(a) Back/neck			
	(b) Wrists/elbows			
	(c) Ankles/knees			
	(d) Shoulders			
	(e) Hips			
9.	Do you have any medical condition or physical disability which could prevent you from:			
	(a) Working at heights			
	(b) Working in a stooped/cramped position			
	(c) Working shift work			
	(d) Heavy lifting activities			
	(e) Working in hot/humid & dusty conditions			
	(f) Repetitive bending or kneeling			
	(g) Walking over rough ground			
	(h) Climbing ladders			
	(i) Walk 1 km on varying grades			
	(j) Work in enclosed spaces			
	(k) Air travel			
10.	Do you have a medical condition which may result in the following events:			
	(a) Loss of consciousness			
	(b) Tripping/falling			
	(c) Loss of balance (including Vertigo or Meniere's disease)			
	(d) Have you ever suffered from Epilepsy?			
11.	Have you ever suffered from Epilepsy?			
12.	Do you suffer from hearing or vision impairment?			
13.	Do you wear prescription glasses or contact lenses?			
14.	Do you have any current medical or health conditions which may affect your ability to perform your intended tasks on site?			
15.	Do you wear a Medic Alert (jewellery and/or tattoo)?			
16.	Do you wear any form of prosthesis (limbs, eye, denture, implants)?			

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		YES (provide details)	NO	DETAILS (include dates, ongoing condition management and emergency considerations):
17.	Do you have any identifying marks (birthmarks, scars, tattoos)?			
Any extra information:				

PRIVACY STATEMENT - HOW YOUR HEALTH INFORMATION IS COLLECTED, STORED AND ACCESSED BY NORTHERN STAR

Provisions of the Privacy Act 1988 (Cth) (Privacy Act) apply to Northern Star and the medical professional's practice engaged by Northern Star to review your responses on this Form. Northern Star maintains a privacy policy. Please contact Northern Star and the medical professional if you would like to view their privacy policies.

All your detailed medical papers including your responses in this Form, test results and the complete record of clinical findings are kept confidential by Northern Star and the medical professional's practice. Other than disclosure between Northern Star and the medical professional, your medical records and personal information will not be disclosed to any other person or organisation without your written permission, except when Northern Star appoints a health professional or other representative to review the information, where required by law, where required in the event of any accident, injury, sickness or claim for workers' compensation relevant to you, or where otherwise permitted by the Privacy Act. This means that your medical records and personal information may be disclosed to (accessed) and used by:

- Northern Star employees, including employees of its related bodies corporate, acting within the scope of their duties related to occupational health and safety and injury management.
- Third parties authorised by Northern Star, including relevant medical practitioners, for occupational health and safety and injury management purposes.

Northern Star and/or the medical professional's practice may be obliged under the Privacy Act to permit you access to/amend or correct information that Northern Star and the medical professional's collect about you on your request. Northern Star acquires a proprietary interest in the results reached (or recommendations made). Please note that unauthorised use of the information released to you as part of the medical assessment, including its provision by you to a third party, is prohibited.

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