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IMPORTANT INFORMATION

TO THE CONTRACTOR/WORKER

- You are required to attend a health assessment to assess your fitness for safety critical work at your transport agency.
- Instructions for arranging your health assessment and preparations you need to do beforehand, are on page 3 on this form.
- The health assessment will include an AS/NZS4308:2008 urine drug test and an alcohol breath test. Contractors who return a positive urine drug or an alcohol breath test reading greater than zero will be certified temporarily unfit until such time as you have successfully completed your transport agency's drug and alcohol rehabilitation program for contractors. Details of the program requirements are available from the RailSafe website at https://railsafe.org.au/
- The authorised health service provider may ask your permission to speak to your general practitioner or treating specialist and if you agree, will then ask you to sign a document providing written consent to such contact.
- If the authorised health service provider finds or suspects something is wrong with your health that you did not know about, they will ask permission to inform your doctor. The examining health professional will not treat any medical condition but will give you a letter to take to your own health professional.
- If the authorised health service provider finds that you do not meet all relevant medical criteria, your manager and your transport agency may discuss the appropriate action to be taken.

TO THE CONTRACTOR/WORKER - DISCLOSURE OF HEALTH INFORMATION

Please read carefully and sign below to indicate your understanding of how your health assessment information will be reported, stored and accessed.

The authorised health service provider retains all detailed medical papers relating to your health assessment including your test results and the completed record of clinical findings. The authorised health service provider only sends the completed Part B Report form and the drug and alcohol test results direct to your firm and your transport agency to indicate your fitness for safety critical work. The details of your health assessment will remain confidential and will only be reported to your firm and to your transport agency in terms of your fitness for safety critical work unless you give the health service provider a separate, specific written authorisation to disclose any relevant medical information that impacts on your ability to do your job.

The exception to the above is that the Chief Health Officer (CHO) or nominated representative of your transport agency may access your full medical records and test results to aid in the management of your health in relation to your work, for audit purposes, or to compile statistics. The CHO or nominated representative must maintain the confidentiality of these records and ensure they are not made available to, or discussed with, any person within your transport agency.

Other than the above, no information will be disclosed to your firm or any other person or organisation without your written permission, except where:

- a notifiable disease is diagnosed which must by law, be reported to the State authorities, or
- a report is subject to subpoena or a statutory disclosure requirement, or
- the rail safety regulator (or another person) is required to conduct an inquiry into a railway accident or incident, or
- a person or organisation is appointed to conduct an audit of the health service provider's compliance with the National Standard for Health Assessment of Rail Safety Workers, or
- de-identified statistical information related to your transport agency's health assessment process is compiled and provided to your transport agency, or
- there is another lawful purpose.

Information collected on this form is subject to privacy laws such as Health Records and Information Privacy Act 2002 (NSW), and Privacy and Personal Information Protection Act 1998 (NSW). Transport agency protects and holds all health and personal information in accordance with policies and procedures. You have the right to access your health records including those held by the authorised health professional and the records held by your transport agency.

CONTRACTOR/WORKERS DECLARATION

I,………………………………………………………………………………… (print name) certify that I have read and understood the above statement concerning the disclosure of my health Information. I understand that if the outcome of the health assessment is temporarily or permanently unfit, or if the drug or alcohol test is positive, a copy of Part B of this form is sent to Transport for New South Wales Learning and Development Branch to manage Rail Industry Worker Card. I agree that this declaration cannot be withdrawn to avoid the consequences of not passing a medical assessment and/or failing a drug or alcohol test.

………………………………….……………….. (Print name) Signature:……………………………………………… Date ……. /…..…/20………

For the Contractor/Worker to complete regarding PORTABILITY OF ASSESSMENT RESULTS

I,………(print name)

Give ☐ Do not give ☐ permission for this health assessment to be forwarded to another rail transport operator as confirmation of fitness for safety critical work. Signature: ………………………………………..……………………………… Date ……. /…..…/20……….

TO THE CONTRACTOR'S FIRM

Please complete all relevant details in Part A of the form including:

- personal details of the worker/applicant, and
- appointment details, once these are confirmed by the health service provider after you have booked the appointment.

Also complete contractor's name, date of birth, contact details, and your transport agency at top of Part B.

Note: To be certain that the individual is fit for rail safety work, the health assessment should be finalised before any relevant training course is booked. Note that the urine drug test results will take at least two days to be available and that the health assessment cannot be finalised without these results.

The authorised health service provider needs to be provided with the original of this form, at least three business days in advance of the scheduled appointment.

TO THE HEALTH PROFESSIONAL

You are requested to conduct a health assessment to assess the worker's / applicant's fitness for safety critical work in accordance with:

- details provided in Part A of this form,
- the National Standard for Health Assessment of Rail Safety Workers, and
- Authorised health professional terms of reference

Please perform the assessment, complete Part B of this form and return it to the nominated contact at the contracting firm according to the instructions in Part A.

NB: If the outcome is temporarily or permanently unfit, and/or if the drug or alcohol test is positive, a copy of Part B should be faxed to Transport for New South Wales Learning and Development Branch on 02 9752 8951 or emailed to rct_competencycards@transport.nsw.gov.au

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PART A– REQUEST FORM – SAFETY CRITICAL EXAMINATION REQUIRED FOR CONTRACTOR

TO: Name of Examiner/Location	
RE: Proposed Examination on (Date/Time)	
Type of Health Assessment Required	☐ **CAT 1 Pre-employment** ☐ **CAT 2 Pre-employment**

SEND INVOICE & HEALTH ASSESSMENT REPORT TO

Nominated Manager's name		**Phone**	
		Mobile	
Name of firm:		**Fax**	
Postal Address			
Postcode:		**Email:**	

CONTRACTOR DETAILS

Family Name:	**First Names:**
Address:	
Postcode:	**Date of Birth:**
Transport agency:	

PROPOSED WORK *(PLEASE TICK APPICABLE RAIL AGENCY):*

Describe the work the contractor will be doing for the transport agency (e.g. track protection, track machine operator, track vehicle operator, mobile plant operator) ⇨ **Describe any additional WH&S requirements** ⇨				
List competencies / qualifications ⇨				
Identify colour vision requirement ⇨	☐ **Normal**	☐ **Defective Safe A**	☐ **Defective Safe B**	☐ **Nil**
Identify hearing requirement ⇨	☐ **Hearing in Noise**		☐ **Hearing in Quiet**	

OTHER TESTS/SERVICES ORDERED

Mandatory drug and alcohol screening tests	☑ *AS/NZS4308:2008* **drug test** from accredited laboratory	☑ **Alcohol breath test** **Note: contractor will have to record a breath alcohol reading of zero.**
Cardiac Risk Assessment Tests (Category 1 only)	☐ **Fasting Cholesterol (total and HDL; and Ratio Total : HDL)**	☐ **HbA1c**

How to arrange the health assessment

Step 1 – Make an appointment to have a blood test (Category 1 only)

- You may attend any pathology collection centre.
- You must have a blood test **at least 3 days before your health assessment appointment.**
- This blood test is used to measure your HbA1c (reflects average plasma glucose concentration) and cholesterol levels.
- Do not eat or drink anything (except water) for at least 8 hours before your blood test. Normally this involves fasting overnight followed by an early morning blood test before having breakfast.
- You will need to advise the pathology collection centre of the name and address of the health service that will be conducting your assessment so that your pathology results may be referred.
- Photo identification will be required.

Step 2 – Make an appointment for your health assessment

- You may select any service from the list of authorised health providers posted at http://railindustryworker.com.au/authorised-health-professionals/. An examination performed by a non-authorised health provider will not be accepted by the transport agency.
- Enter details of your appointment below as a reminder.

Time	
Date	
Name and address of health provider	

Step 3 – Complete the health questionnaire on the following two pages

- The questionnaire is a screening tool to help identify conditions that might affect the performance of safety critical work.

Step 4 – Attend the health assessment

Take with you to your health assessment appointment:

- The health questionnaire (completed but not signed)
- A list of all medications you are taking, including over-the-counter medicines.
- Any relevant medical reports or test results
- Your HbA1c and/or blood sugar record (if you are diabetic)
- Photo identification
- Any spectacles, contact lenses, hearing aids or any other aids required for your work.

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SAFETY CRITICAL WORKER – HEALTH QUESTIONNAIRE

For privacy reasons, the completed questionnaire MUST NOT be returned to the transport agency (except on request to the Chief Health Officer or nominated representative who must maintain privacy). The health service provider retains the completed questionnaire in the worker's health record file.

☐ CAT 1 – HIGH LEVEL SAFETY CRITICAL WORKER	☐ CAT 2 - SAFETY CRITICAL WORKER

Worker Details

Family name:	**First names:**	
Address:	**Suburb/State:**	
Postcode:	**Date of birth:**	**Home Phone/mobile:**
Transport agency:		

**COMPLETE ALL THE ANSWERS TO THIS QUESTIONNAIRE BEFORE ATTENDING THE MEDICAL EXAMINATION.
SIGN THE FOLLOWING DECLARATION WHEN YOU ARE WITH THE EXAMINING HEALTH PROFESSIONAL.**

I, ………………………………………………………………………………………………….(print name) certify that to the best of my knowledge all the information supplied in the following questionnaire is true and correct.

Signature of worker……………………………………………….……

Date: ……./…………/………..20……....

Witnessed by
Health Professional………………………………………….………

Date: ……./…………/………..20……....

Safety Critical Worker – Health Questionnaire – Page 1

		NO	YES
1.	**Are you currently being treated by a doctor for any illness or injury?**	☐	☐
2.	**Are you receiving any medical treatment or taking any medication (prescribed or otherwise)?** *Provide brief details below and take your medications with you to show the doctor* ……………………………………………………………………………… ……………………………………………………………………………… ………………………………………………………………………………	☐	☐
3.	**Have you ever had, or been told by a doctor that you had, any of the following:**		

		NO	YES			NO	YES
3.1	High blood pressure	☐	☐	3.14	Memory loss, difficulty with attention or concentration	☐	☐
3.2	Heart disease	☐	☐	3.15	Diabetes	☐	☐
3.3	Chest pain, angina	☐	☐	3.16	Neck, back or limb disorders	☐	☐
3.4	Any condition requiring heart surgery	☐	☐	3.17	Hearing loss or deafness or had an ear operation or use a hearing aid	☐	☐
3.5	Palpitations / irregular heartbeat	☐	☐	3.18	ADHD, autism, Asperger's, cognitive impairment or any other cognitive or developmental condition	☐	☐
3.6	Abnormal shortness of breath or chest diseases			3.19	A psychiatric illness or nervous disorders	☐	☐
3.7	Head injury, spinal injury	☐	☐	3.20a	Have you ever been a smoker?	☐	☐
3.8	Seizures, fits, convulsions, epilepsy	☐	☐	3.20b	How many cigarettes per day do/did you smoke?	……………..	
3.9	Blackouts or fainting	☐	☐	3.20c	If you were a smoker, when did you quit?	……………..	
3.10	Stroke	☐	☐	3.21	Do you use illicit drugs? *(If yes, briefly describe)*	☐	☐
3.11	Dizziness, vertigo, problems with balance	☐	☐	3.22	*Have you ever had any other serious injury, illness, operation, or been in hospital for any reason? (If* yes, briefly describe)	☐	☐
3.12	Double vision, difficulty seeing or difficulty adapting to changing light conditions	☐	☐				
3.13	Colour blindness	☐	☐				

CLINICAL NOTES

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Safety Critical Worker – Health Questionnaire – Page 2

For privacy reasons, the completed questionnaire MUST NOT be returned to the transport agency (except on request to the Chief Health Officer or nominated representative who must maintain privacy). The health service provider must retain the completed questionnaire in the worker's health record file.

4	SLEEP	NO	YES	Clinical Use Only
4.1	Have you ever had, or been told by a doctor that you had, a sleep disorder, sleep apnoea, or narcolepsy?	☐	☐	
4.2	Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep?	☐	☐	……………

	EPWORTH SLEEPINESS SCALE **How likely are you to doze off or fall asleep (rather than feeling just tired) in the following situations?** *This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.* **Tick the box that best describes your behaviour in each situation.**	0 **Would never doze off**	1 **Slight chance of dozing**	2 **Moderate chance of dozing**	3 **High chance of dozing**	…………… …………… …………… …………… …………… **Official Use Only**
4.3	Sitting and reading	☐	☐	☐	☐	
4.4	Watching TV	☐	☐	☐	☐	
4.5	Sitting, inactive in a public place (eg. a theatre or a meeting)	☐	☐	☐	☐	
4.6	As a passenger in a car, for an hour without a break	☐	☐	☐	☐	
4.7	Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐	
4.8	Sitting and talking to someone	☐	☐	☐	☐	
4.9	Sitting quietly following lunch with no alcohol	☐	☐	☐	☐	
4.10	In a car, while stopped for a few minutes in the traffic	☐	☐	☐	☐	
					TOTAL	

	5. AUDIT QUESTIONNAIRE (this relates to your intake of alcohol). **Tick the box Please circle the answer that is correct for you:**	0	1	2	3	4	Clinical Use Only
5.1	How often do you have a drink containing alcohol?	Never (go to Section 6)	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
5.2	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 to 4	5 to 6	7 to 9	10 or more	
5.3	How often do you have six or more drinks on one occasion?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
5.4	How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
5.5	How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
5.6	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
5.7	How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
5.8	How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
5.9	Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
5.10	Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
						TOTAL	

	6. K10 QUESTIONNAIRE (this relates how you feel) **Tick the box that is correct for you.** **In the past 4 weeks, about how often did you feel:**	1 **None of the time**	2 **A little of the time**	3 **Some of the time**	4 **Most of the time**	5 **All of the time**	Clinical Use Only
6.1	Tired out for no good reason?	☐	☐	☐	☐	☐	
6.2	Nervous?	☐	☐	☐	☐	☐	
6.3	So nervous that nothing could calm you down?	☐	☐	☐	☐	☐	
6.4	Hopeless?	☐	☐	☐	☐	☐	
6.5	Restless or fidgety?	☐	☐	☐	☐	☐	
6.6	So restless you could not sit still?	☐	☐	☐	☐	☐	
6.7	Depressed?	☐	☐	☐	☐	☐	
6.8	That everything was an effort?	☐	☐	☐	☐	☐	
6.9	So sad that nothing could cheer you up?	☐	☐	☐	☐	☐	
6.10	Worthless?	☐	☐	☐	☐	☐	
						TOTAL	

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PART B – HEALTH ASSESSMENT REPORT

This report should not contain any private medical information

Health Professional's Contact Details *(stamp)* Address…………………………………………………………………… …………………………………………………………………………… …………………………………………………………………………… …………………………………………………………………………… Phone: ………………………… Fax ………………………………	**Contractor's Family Name** **Contractor's First Names** **Contractor's Date of Birth** **Contractor's Transport Agency:**

Contact in contractor's firm	**Name:**	**Phone:**
	Fax:	**Email:**

I (insert name of examining health professional**)** ……………………………………………………………………………certify that

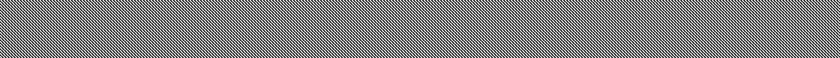
I examined the proposed contract worker on ………/………/20…… **in accordance with the National Standard for Health Assessment of Rail Safety Workers**

Category of examination performed - ☐ **CAT 1** ☐ **CAT 2**

This is the **FINAL REPORT** on the proposed contract worker's **Pre-placement** health assessment

I have sighted the worker's Photo ID (Type…………………………………………………Number………………………………)

Alcohol breath / urine drug test results were: ☐ Positive ☐ Negative

In my opinion the proposed contract worker is *(choose one option)*	**And I recommend**
FIT FOR DUTY, UNCONDITIONAL …………………..☐ Meets all relevant medical criteria	
FIT FOR DUTY, CONDITIONAL……………………….☐ Meets all relevant medical criteria if complies with conditions	Must wear corrective lenses ☐ Must wear hearing aid(s) ☐
FIT FOR DUTY, SUBJECT JOB MODIFICATION ………………………………………☐	**JOB MODIFICATION REQUIREMENTS:**
FIT FOR DUTY, SUBJECT TO REVIEW………………☐ - Does not meet all medical criteria - Could perform the required rail safety work if: 1. The condition is sufficiently under control, and 2. The worker is more frequently reviewed than prescribed under the periodic review **This certificate valid to……./………../ 20………..**	**LIST OF REVIEWS REQUIRED** (give details in **NOTES**) ☐ Laboratory tests ☐ I have asked the worker to book a review by their local doctor / specialist ☐ Review at this practice ☐ Review by specialist …………………………………………………………… ☐ Review required at: …………………………………………………………… ☐ Earliest possible review date: ….. /……../20…… Time: ____:_____ **AHP TRIGGERED ASSESSMENT ACTION / PREPARATION REQUIRED:** ☐ Blood Test (Category 1) ☐ Audiometry ☐ ECG ☐ Others …………………
TEMPORARILY UNFIT FOR DUTY, SUBJECT TO REVIEW ……………………………….☐ - Does not meet all medical criteria or tested positive to drugs or alcohol - Cannot perform the required rail safety tasks - May perform alternative tasks - May perform the full rail safety duties required only after improvement in condition, response to treatment etc as confirmed by medical review **This certificate valid to……./………../ 20………..**	**NOTES TO EMPLOYER** (*Attach extra sheets if required*) Explain: duties which will / may cause problems for the applicant and any action needed to facilitate / manage a review …………………………………………………………………………… …………………………………………………………………………… …………………………………………………………………………… …………………………………………………………………………… …………………………………………………………………………… …………………………………………………………………………… ……………………………………………………………………………
PERMANENTLY UNFIT FOR DUTY ……………………☐ - Does not meet the medical criteria - Cannot perform the job in future	
Signature of AHP: ……………………………………… Date: ……/……../20………	Signature of reviewing Occupational Physician …………………………… Date: ……/……../20……….

TRANSPORT AGENCY OFFICIAL USE ONLY

The health assessment report certifying the contractor as fit was received & recorded on date: ………/………/20……….b y ………………………