



SECTION 1 - PERSONAL DETAILS

Company/Organisation: Job title:
Surname: Forenames: Date of Birth:
Location / Depot: Service:
Employee Number: Date of Previous Screening:
Home Address:
Line Manager: Line Manager's
email address:

Data Protection Act 1998 - Personal information generated by completion of this form provides a medical view of your fitness for employment or specific task. Without this information your application/assessment of fitness will not proceed further. Your consent will be sought for any other use of all or part of this confidential medical data.

SECTION 2 - HAND ARM VIBRATION SYNDROME (HAVS) ASSESSMENT

This assessment is to be completed by all people who currently use hand held vibrating tools (including hand guided vibrating machines and handfed vibrating machines) or those people that have used them in the past two years.

Serco Occupational Health will use this information in order to provide guidance to both you and your employers on your fitness to work with vibrating tools. This might involve the need for you to attend for a more detailed medical assessment.

	Yes	No	Details & Dates (Give full information where applicable)
1. Do you use handheld vibrating tools at work?	<input type="checkbox"/>	<input type="checkbox"/>	Year of first exposure -
2. If this is a review assessment, have you used handheld vibrating tools in your job since your last assessment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any numbness or tingling of the fingers lasting more than 20 minutes after using vibrating equipment?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have numbness or tingling of the fingers at any other time?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you wake at night with pain, tingling or numbness in your hand or wrist?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you suffered with all or part of your fingers going white on exposure to cold? (Whiteness means a clear discolouration of all or part of a finger, with a sharp edge, usually followed by a red flush)	<input type="checkbox"/>	<input type="checkbox"/>
7. If you have noticed any of the symptoms mentioned in Q 3-6, are they making it more difficult to work outside in the cold than at your last assessment?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you experiencing any other problems with your hands or arms?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had difficulty picking up very small objects such as screws or buttons, or opening tight jars?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you noticed any other symptoms, since your last assessment, which you feel may be related to working with vibrating tools?	<input type="checkbox"/>	<input type="checkbox"/>

Name -	Date of Birth -	Date of Assessment -
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SECTION 3 - CONSENT & DECLARATION

I hereby declare that all medical information given by me to Serco Occupational Health is true and accurate to the best of my belief and knowledge. I consent for Serco Occupational Health to provide fitness for work guidance to my employer.

Signature of Applicant Date

SECTION 4 - OUTCOME (Serco Occupational Health Use Only)

Referred for further assessment Yes No

Follow up Surveillance Planned and Timescale? (i.e. Tier 2 in 12 months, Tier 3 in 12 months, referred for further assessment) -

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Name/Role (ie OHA /OHP) Signature: Date: