PRESCRIBED & OVER-THE-COUNTER MEDICATION DECLARATION

***ALL SECTIONS MUST BE COMPLETED**

SECTION 1: EMPLOYEE DETAILS	
Surname:	First Name:
Date of Birth:	Mobile Number:
Company:	Site:
NSR Supervisor / Site Contact:	Company Contact (Contractors Only):
Job Role:	Workgroup:

SECTION 2: 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

SECTION 3: SIDE EFFECTS

Provide information on any side effects that you are experiencing from the medication:

I declare that:

a) I consent to the collection, use and disclosure of my medical information in this form;
b) I consent to clarification of medical information with my treating medical practitioner if necessary;
c) I have disclosed information on this form honestly, correctly and completely.
d) I have not knowingly withheld any relevant information.
e) I understand that incorrect or misleading statements or omissions may;
   i. result in the termination of any employment by Northern Star;
   ii. negate any future claim for compensable injury/illness.

Information about the privacy of your health and medical information is provided overleaf.

SIGNATURE	
Employee / Contractor:	Date:

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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. 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 the Pre-Employment Medical 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 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.

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 propriety interest in the results reached (or recommendations made). Information collected by Northern Star may be disclosed to its subsidiary companies in the United States, if employment, transfer of site or change of role is relevant to Northern Star's United States operations. 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.

Section 4 must be completed on this form or electronically through The Health and Safety Hub e-sign.

SECTION 4: SITE MEDIC OR ESSO	
Medic or ESSO Name:	
Prescription Reviewed: Yes ☐ No ☐	Personal Clinic Profile Updated: Yes ☐ No ☐
Signature:	Date:
Known, suspected or possible side effects that individual is actually experiencing from the medication: **Where further information is required to determine the Workers fitness for work due to the medication or for possible side effects, combination of medications, schedule 8 medications, THC or CBD containing medications or other, section 5 must be completed.**	

SECTION 5: NSR MEDICAL PROVIDER REVIEW	
Fit for Work: Yes ☐ No ☐	Requires further Fit for Work Evaluation: Yes ☐ No ☐
Modified Duties: Yes ☐ No ☐ Supervisor advised: Yes ☐ No ☐	Personal RTW Plan Completed: Yes ☐ No ☐
Doctor's Name:	Date:
Signature:	
Comments:	