MOBILE ELEVATED WORK PLATFORM QUESTIONNAIRE

Name:

Date of Birth:

Job Title:

Department:

Company:

Hours per week using MEWP

Have you ever suffered from the following:

Been away from work for more than 3 weeks on sick leave?	☐ Yes	☐ No
Suffered from dizziness or fainting attacks?	☐ Yes	☐ No
High blood pressure?	☐ Yes	☐ No
Chest pains or angina?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No
Epilepsy?	☐ Yes	☐ No
Head injury or been knocked unconscious?	☐ Yes	☐ No
Depression, anxiety or stress?	☐ Yes	☐ No
Eye disease or past eye injury?	☐ Yes	☐ No
Ear injury/frequent ear infections?	☐ Yes	☐ No
Are you taking any medication?	☐ Yes	☐ No
Do you drink alcohol?	☐ Yes	☐ No
Do you take regular exercise?	☐ Yes	☐ No
Do you have any back or joint problems?	☐ Yes	☐ No

Other relevant information (any recent illnesses/ops/family history):

Do you have a full driving licence? ☐ Yes ☐ No

Employee Declaration

I consent to undertaking a Mobile Elevated Work Platform Examination and a standard pro-forma being provided to management confirming the results of this examination.

Additional consent will be obtained should any result of this examination need to be discussed with Management.

By ticking this box ☐ you are signing an agreement to the following statements:
I declare that all the foregoing statements are complete and true to the best of my knowledge.

Signature:

Date:

Submit