

10.3 – Personal Medical Data (Confidential)



GENERAL

Name:	Date:
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EMERGENCY CONTACT INFORMATION

Name	Phone	Cell

MEDICAL INFORMATION

Do you wish to voluntarily provide medical information for the safe identification of work tasks and or emergency assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergies:	
Conditions:	
Medications:	

MEDICAL INFORMATION

Do you wish for the employer to verbally notify any designated site personnel of your medical information described above? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, who: <input type="checkbox"/> site supervisor <input type="checkbox"/> foreman <input type="checkbox"/> first aid attendant	
Signature:	Date:

** This document will be kept confidential in the appropriate employee file – no copies will be produced or kept at the worksite.*

Worker signature:	Conducted by:
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