(Carried out in line with Regulation 16 of the Management of Health & Safety at Work Regulations 1999)

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| 1. NAME : | 2. DEPT : | | |
| 3. DATE OF INITIAL ASSESSMENT : | 4. DATE PREGNANCY NOTIFIED :  (In writing) | | |
| 5. CERTIFICATE SUPPLIED (MD OR REGISTERED MIDWIFE) : | | YES | NO |
| 6. POSITION IN FIRM AND BRIEF DESCRIPTION OF TYPE OF WORK CARRIED OUT : | | | |
| a) Does the employee carry out any manual handling operations? | | YES | NO |
| b) Does the employee work with any harmful substances? | | YES | NO |
| c) Does the employee carry out any other hazardous function? | | YES | NO |
| 7. IF 'YES' TO ANY OF THE ABOVE, GIVE DETAILS : | | | |
| 8. WHAT HOURS ARE WORKED?  DO THESE NEED TO BE MODIFIED? | | | |
| 9. WHAT CHANGES TO WORK PRACTICES ARE REQUIRED AT THIS STAGE TO MINIMISE RISK : | | | |

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| 10. WHAT MEASURES HAVE BEEN AGREED SHOULD THE EMPLOYEE BECOME ILL AT WORK:   1. To rest and recuperate on site : 2. To return home (if necessary) : | |
| 11. FOLLOW UP MEETING (ONE) (Amendments to Box 8/9) : | |
| 12. FOLLOW UP MEETING (TWO) (Amendments to Box 8/9) : | |
| 13. FOLLOW UP MEETING (THREE) (Amendments to Box 8/9) : | |
| Date maternity leave expected to commence : | |
| Date of next assessment meeting :  2.  3. 4. | |
| I agree that this is a true record of the above meeting : | |
| Signature of Assessor : | Signature of Employee : |
| Position : | Date : |