(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) :
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| 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 : |