

# Request by past or present worker for medical examination

## Who should use this form?

This form is used by a person who has been exposed to hazardous dust while employed as a NSW worker and who is seeking medical assessment to determine if the person has contracted a compensable dust disease.

## Instructions for completing this form

- You must complete every question in this form and answer each question fully and truthfully.
- If you do not know the answer to a particular question you should state this in your answer.
- Another person may complete this form on your behalf. However, only you or your Power of Attorney can declare the information to be true and correct and sign at the end of this form.
- You have a continuing obligation to provide us with all information relevant to your matter. If you obtain or remember additional facts or information, you must advise the DDB immediately.

**If you need help filling out this form or require an interpreter please telephone us on 02 8223 6600 or 1800 550 027 (freecall).**

## Where to send this form

This form should be addressed to:

### Workers' Compensation Dust Diseases Board

GPO Box 5323  
Sydney NSW 2001

Telephone: (02) 8223 6600

Toll free: 1800 550 027

Fax: (02) 8223 6699

Email: [enquiries@ddb.nsw.gov.au](mailto:enquiries@ddb.nsw.gov.au)

Office Hours: Mon to Fri – 9am to 5pm

### Office Use only

DDB File Number

Date Received (DD/MM/YYYY)

## Part 1. Your personal details

### 1. Have you been previously examined for a dust disease by the DDB?

☐ Yes ☐ No

### 2. Name

Title

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

First name

Middle name(s)

Last name

### 3. Have you used any other names?

☐ Yes ☐ No If yes, please provide details below

First name

Middle name(s)

Last name

### 4. Gender

☐ Male ☐ Female

### 5. Date of birth (DD/MM/YYYY)

/  /

### 6. Relationship status

Are you currently:

☐ Single ☐ Married ☐ De facto ☐ Divorced ☐ Separated ☐ Widowed

### 7. Home address

Number

Street

Suburb

State

Postcode

## Part 1. Your personal details (continued)

## 8. Postal address

Are your home and postal addresses the same?	Yes	No
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If **no**, please advise your postal address below

Number

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Street

[illegible]

Suburb

[illegible]

State

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Postcode

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## 9. Contact details

Phone (Home)

(    )

Phone (Work)

(    )

Phone (Mobile)



Fax

(    )   

Email

[illegible]

Please state your preferred method of contact:

[illegible]

## 10. Additional questions

10.1. Do you speak a language other than English at home? ☐ Yes ☐ No

If **yes**, what language?



10.2. Do you need an interpreter? ☐ Yes ☐ No

If **yes**, what language?

[illegible]

10.3. Do you have any needs that affect how you access our services? e.g. disability, cultural, religious

☐ Yes ☐ No

If **yes**, what practical support do you need to access our services e.g. Auslan interpreter, wheelchair access?

## PART 2. Your dust exposure

### 11. Provide the following details of your workplace exposure to dust:

Period of exposure (start and end date) (DD/MM/YY)	Name of employer and location in which the workplace was located	What dust were you exposed to?	How were you exposed to dust in this workplace?
Start <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> End <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	State <input type="text"/> Country <input type="text"/>	<input type="checkbox"/> Asbestos <input type="checkbox"/> Silica <input type="checkbox"/> Hard metals <input type="checkbox"/> Talc <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify <input type="text"/>	
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## PART 3. Agent authority

### 12. Do you give authority for another person to provide and receive information and/or make enquiries on your behalf?

☐ No ☐ Yes, provide the details below

Name of authorised person

Address

Number

Street

Suburb

State

Postcode

Phone number

()

Relationship to you

## PART 4. Consent

By signing this form you are consenting to a respiratory medical examination by a medical practitioner. A detailed description of what is involved in a DDB respiratory medical examination is available as a factsheet from the DDB. You can ask any questions about a DDB respiratory medical examination by telephoning the DDB on (02) 8223 6600 or toll free on 1800 550 027. You can withdraw this request form and your consent at any time.

## PART 5. Privacy Statement

Your personal information is protected by law. We cannot use or disclose personal information about you unless you have agreed to its use or disclosure, or it is otherwise allowed under the *Privacy and Personal Information Act 1998*. Please read the DDB Privacy Disclosure Statement. The document explains how the DDB uses, stores and disposes of your personal information.

## PART 6. Signature and declaration

I, [Name],

of [Address],

Number

Street

Suburb

State

Postcode

solemnly declare that I conscientiously believe the answer to each and every question on this form and the particulars contained therein or attached hereto to be true. I consent to a respiratory medical examination by a medical practitioner. I understand the DDB's privacy disclosure statement.

Signature:

Date,

(DD/MM/YYYY):