

Notifiable Occupational Disease System

1. Surname:
2. Given names:
3. Home address:
.....
.....
4. Telephone number(s):
home ()
work ()
mobile ()
email
5. Date of birth: / /
day month year
6. Ethnic origin:
 NZ Pakeha Maori
 European Samoan
 Tongan Cook Island Maori
 Nuiean Chinese
 Indian Asian
 Other:
7. Employer's name and address:
Name:
Address:
.....
.....
8. Description of the work area:
.....
.....
.....
.....
9. Name and address of patient's GP:
.....
.....
10. Who is making this notification?
 GP Self **Go to question 12**
 Physiotherapist Occ. health nurse
 Occ. therapist Specialist
 Union rep.
11. Name and address of person making this notification (if not self or GP):
.....
.....
12. Has the person's employer notified the Department of Labour about serious harm in connection with this case?
 Yes No Don't know

13. Suspected disease
 Disease caused by a chemical agent
 (e.g. lead poisoning; solvent-induced neurotoxicity)
 Disease caused by a physical agent
 (e.g. noise-induced hearing loss, hand-arm vibration syndrome)
 Disease caused by a biological agent
 (e.g. leptospirosis)
 Occupational respiratory disease
 (e.g. occupational asthma or an asbestos-related disorder such as mesothelioma, asbestosis, lung cancer, pleural plaques or pleural thickening)
 Occupational skin disease
 Occupational musculoskeletal disorder
 (Note: A term such as "OOS" must be accompanied by a precise diagnosis such as "medial epicondylitis".)
 Mental and behavioural illness
 Occupational cancer

Please specify the precise diagnosis and/or causative agent:

.....

14. **Consent:** I, the above-named, agree to:
 1. An interview, if needed, by qualified Department of Labour personnel, to obtain information about my medical, social and work history.
 2. Qualified Department of Labour personnel having access to my medical records and investigations, if appropriate.
 3. I understand that access to my NODS data is only available to Department of Labour, ACC, myself and my medical providers. Any other request for access to or use of information must be accompanied by my written consent.
 4. I understand that this notification may result in a workplace assessment by qualified Department of Labour personnel.

15. Signed (by patient):

16. Date: / /
day month year

Department of Labour use only: Case Number

FOLD HERE

Notifiable
Occupational
Disease
System

No postage stamp required
if posted in NZ



BUSINESS REPLY POST
Authority No. 3425 Wellington NZ
Postage and fee will be paid on delivery to:

Notifiable Occupational Disease System
Department of Labour
PO Box 3705
Wellington

Department of Labour
TE TARI MAHI

