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|  | **Pregnancy and new mother’s Risk Assessment Form** | | | |  |
| Created/Revised by: | |  | Effective Date:31/05/22 | Rev -A |

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| **Location : Department:** | | | |
| **Employee’s name** | **Job Title/ description of tasks** | **Date of**  **Assessment** |  |
|  |  | **Assessment No.** |  |

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| **No** | **Hazards identified** | **Y** | **Existing controls** | **Severity** | **Likelihood** | **Risk Rate** | **Significant**  **Yes / No** | | **Persons at Risk**  **& Nos.** | **Further Action Required (see Action Plan)** | **Residual risk acceptable** |
| 1 | Assaults/ violence |  |  |  |  |  |  |  |  |  |  |
| 2 | Biological hazards |  |  |  |  |  |  |  |  |  |  |
| 3 | Chemical hazards (COSHH) |  |  |  |  |  |  |  |  |  |  |
| 4 | Display Screen Equip. (DSE) |  |  |  |  |  |  |  |  |  |  |
| 5 | Fire |  |  |  |  |  |  |  |  |  |  |
| 6 | Manual handling |  |  |  |  |  |  |  |  |  |  |
| 7 | Noise |  |  |  |  |  |  |  |  |  |  |
| 8 | Posture, stand, sitting, stairs |  |  |  |  |  |  |  |  |  |  |
| 9 | Pregnancy related issues |  |  |  |  |  |  |  |  |  |  |
| 10 | Radiations (x-rays etc.) |  |  |  |  |  |  |  |  |  |  |
| 11 | Rest facilities/ fridge |  |  |  |  |  |  |  |  |  |  |
| 12 | Shift work, travel, excessive hours |  |  |  |  |  |  |  |  |  |  |
| 13 | Shocks, movements & vibration |  |  |  |  |  |  |  |  |  |  |
| 14 | Smoking, passive smoking |  |  |  |  |  |  |  |  |  |  |
| 15 | Stress, fatigue |  |  |  |  |  |  |  |  |  |  |
| 16 | Temperature extremes |  |  |  |  |  |  |  |  |  |  |
| 17 | Working at heights |  |  |  |  |  |  |  |  |  |  |
| 18 | Working alone |  |  |  |  |  |  |  |  |  |  |
| 19 | Awkward spaces/ workstation layout |  |  |  |  |  |  |  |  |  |  |
| 20 | Other (not incl. above) |  |  |  |  |  |  |  |  |  |  |

**Assessors’ Signature**: **Employees Signature:** **Manager’s Signature:** **Date:**

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|  | **Pregnancy and new mother’s Risk Assessment Action plan** | | | |  |
| Created/Revised by: | |  | Effective Date: 31/06/22 | Rev - A |

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| **Location : Department:** | | | |
| **Employee’s name** | **Job Title/ description of tasks** | **Date of**  **Assessment** |  |
|  |  | **Assessment No.** |  |

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| **Activity / Work Hazard** | **Action to be taken** | **Person(s) responsible** | **By when?** | **Completed**  **Signature Date** | |
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| **Discussion Record** |
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| **Has the employee been referred to their own doctor or to Occupational Health?** |

**Assessors’ Signature**: **Employee’s Signature:** **Manager’s Signature:** **Date:**