



Employee Application for Nicotine Replacement Therapy

This form is to be completed by Dental Health Services (DHS) employees wishing to quit smoking and access Nicotine Replacement Therapy (NRT)

Name of Employee: _____

Designation: _____

Location: _____

Telephone: _____

How many cigarettes do you smoke per day?

- 10 or less
- 11 - 20
- 21 - 30
- 31+

How soon after waking do you smoke your first cigarette?

- Within 5 minutes
- 5 – 30 minutes
- 31 – 60 minutes
- 60+ minutes

Are you under the age of 18yrs?	YES / NO
Have you had a myocardial infarction?	YES / NO
Are you affected by unstable angina?	YES / NO
Are you affected by severe arrhythmias?	YES / NO
Have you recently suffered a recent CVA/stroke?	YES / NO
Are you affected by severe psoriasis?	YES / NO
Are you pregnant?	YES / NO
Are you lactating?	YES / NO
Are you a non-smoker?	YES / NO
Do you suffer from a medical condition that requires medication?	YES / NO
Do you have any allergies?	YES / NO
If you answered “no” to all of the above , make an appointment with your manger.	
If you answered “yes” to any of the above , you will need to be assessed by your doctor and have a medical certificate stating that it is safe for you to use NRT.	

- I have read and understand all of the information in this application
- I smoke more than 10 cigarettes per day or have my first cigarette within 30 minutes of waking.
- I will read the Consumer Medication Information (CMI) on receipt of the NRT
- I am aware that I can contact Quitline (13 7848) and www.quitenow.gov.au for further assistance and information.

The information I have provided is true and correct. I consent to DHS being notified on completion of my course of NRT.

Name (please print)

Signature

Date

Please forward this form to Manager Corporate Services for approval.

To Be Completed by Manager Corporate Services	
Employee Name	
Employee Number	
signature	
Cost Centre	
Date	

Employee to Fax or take this form to your local WA Health Pharmacy

To Be Completed by Pharmacy						
NRT Dispensed	7,14 or 21mg patches	2 or 4mg lozenges/gum	Name:	Signature:	Date:	Cost:
___ weeks NRT provided						
___ weeks NRT provided						
___ weeks NRT provided						
___ weeks NRT provided						
Additional NRT provided (if Applicable) ___ weeks						

Pharmacist: Fax or email a copy of the completed form to Dental Health Services:

Fax: 9313 1302

DHS.HumanResources@health.wa.gov.au