## **APPENDIX I**

## **EMPLOYEE AUTHORISATION**

l	, an employ	ee of	
	consent to my treating Medical Practition		
Name:			_
Address:			_
			_
			_
			_
Phone:			<del></del>
	th my employer's Occupational Health or illness information to assist with the ork Plan.	•	
	Employee Signature		 Date
	Witness Signature		 Date