



Employee Application for Nicotine Replacement Therapy

This form is to be completed by employees who wish to quit smoking and take up the offer of 8 weeks free Nicotine Replacement Therapy (NRT)

Name of employee requesting free NRT _____

Health service _____

Department _____

Telephone _____

Number of cigarettes smoked per day 10 or less

11 -20

21-30

How soon after waking do you smoke your first cigarette? Within 5 minutes

5 – 30 minutes

31 - 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 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 mental health condition that requires medication?	YES / NO

If you have answered 'no' to all of the above, make an appointment with your manager.

If you have 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 with 30 minutes of waking.
- I will read the Consumer Medication Information (CMI) of receipt of the NRT.
- I have not had more than one course of free NRT during the previous 12 months.
- I am aware of the benefits of training nicotine replacement therapy to assist me to quit smoking and wish to participate in the 8 weeks free NRT offer.
- I am aware that I can contact Quitline for assistance (13 7848) and access www.quitnow.gov.au during work hours.

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

Name (please print)

Signature

Date

In order to measure the effectiveness of the NRT offer to employees as a smoking cessation aid we would like to phone you in six months time to follow up. If you **do not** wish to participate in a follow up telephone call please check this box.





To be completed by Manager	
Employee Name	
Employee Number	
Name and signature of Manager	
Fax number of Manager	
Cost centre number	
Date	

Staff member: Fax or take this form to your local WA Health Pharmacy

To be completed by Pharmacy						
NRT Dispensed	1, 14 or 21mg patches	2 or 4mg lozenges/gum	Name	Signature	Date	Cost
4 weeks free NRT provided						
4 weeks free NRT provided						
Additional NRT provided (if applicable) ___ weeks						

Pharmacist: Fax or use internal mail to send a copy of the completed form to employee's line manager.

