

**AGAINST ADVICE FORM**

Name of First Aider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Site: \_\_\_\_\_\_\_\_\_\_

ACTION ADVISED BY THE ABOVE:

HAVING BEEN FULLY ADVISED OF THE POSSIBLE COSEQUENCES OF MY ACTIONS, I DECLARE THAT I DO NOT WISH TO ACCEPT THIS ADVICE.

NAME:

SIGNATURE:

DATE:

PLEASE SEND THE COMPLETED FORM TO SITE OCCUPATIONAL HEALTH TEAM