

OCCUPATIONAL FIRST AID MEDICAL CERTIFICATE OF FITNESS Report of Examining Physician

EXAMINING PHYSICIAN PLEASE NOTE:

1. **When completing please pay particular attention to questions 4, 5 and 10.**
2. It is essential that the candidate be **PHYSICALLY AND PSYCHOLOGICALLY** fit to perform the duties of an Occupational First Aid Attendant.
3. The fee for the services of the physician is the responsibility of the candidate.

PLEASE PRINT

Surname of candidate	Given names in full	Date of birth (Month/Day/Year)
Mailing Address - Street	City/Province	Postal Code

1. DISEASE CONDITIONS – Is there MEDICAL EVIDENCE AND/OR A HISTORY of:

Seizure disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Communicable disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (not otherwise specified)	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, please explain if this disease could affect the candidate's ability to perform the duties of an Occupational First Aid Attendant

2. ALCOHOL OR SUBSTANCE ABUSE – Has the candidate experienced any problems in the PREVIOUS 12 MONTHS, relative to the overuse and/or addiction to ALCOHOL, RECREATIONAL or PRESCRIPTION DRUGS, and/or OVER THE COUNTER MEDICATION?

Yes No

If yes, please explain _____

3. PSYCHOLOGICAL AND/OR EMOTIONAL ILLNESS – At the work site, first aid attendants may be involved in stressful, emotional, and/or tense situations. Has the candidate exhibited and/or experienced any PSYCHOLOGICAL OR EMOTIONAL episode which could preclude the candidate from performing the duties of an Occupational First Aid Attendant?

Yes No

If yes, please explain _____

4. VISUAL ACUITY – Would the candidate (with appropriate visual correction, if required) be able to observe an accident scene from a distance, assess minor wounds, remove small slivers, remove small particles from the eye, and/or assess a patient for pallor and contusions?

Yes, able to perform required tasks
 No, not able to perform required tasks

If no, please explain _____

5. HEARING ACUITY – Would the candidate (with appropriate hearing correction, if required) be able to hear a summons for first aid, hear and assess breathing on a patient who may not be visible to him/her, distinguish if there is distressed breathing, and/or verbally communicate with a patient?

Yes, able to perform required tasks
 No, not able to perform required tasks

If no, please explain _____

OCCUPATIONAL FIRST AID MEDICAL CERTIFICATE OF FITNESS (continued)

6. FINE MOTOR SKILLS – UPPER LIMBS – Does the candidate have a MOTOR OR SENSORY impairment of one or both of the upper extremities which could impair his/her ability to assess a pulse, palpate for point tenderness, remove particles from the eye, immobilize a limb, assess and treat open wounds? Yes No

If yes, please explain _____

7. PHYSICAL FITNESS – First Aid Attendants may have to traverse rough terrain such as steep banks, climb over fallen trees or logs, access areas such as excavations or high elevations. Does the candidate have a physical condition which could limit his/her ability to render first aid under these conditions? Yes No

If yes, please explain _____

8. LIFTING ABILITY – First Aid Attendants may have to assist in transporting a patient, secured to a lifting device, over rough terrain. They may also have to carry equipment weighing up to 50 lbs. (22.680 kg). Does the candidate have a physical condition which could limit his/her ability to render first aid under these conditions? Yes No

If yes, please explain _____

9. Is the candidate taking any medication which could affect his/her ability to render first aid? Yes No

If yes, please explain _____

10. In summary, in your PROFESSIONAL OPINION, do you have confidence in this candidate's PHYSICAL and/or PSYCHOLOGICAL FITNESS to render emergency pre-hospital care to workers?

Yes, I have confidence

No, I do not have confidence

If no, please explain _____

Physician's name (please print) Physician's signature Phone number (please include area code)

Street address City Province Postal code

Date (Month/Day/Year) Clinic or physician's stamp

Candidate's Statement

I have answered all questions from my physician, Dr. _____, honestly and truthfully, and I was forthcoming with

Dr. _____ regarding any physical or mental condition that would have a bearing upon my PHYSICAL or MENTAL ASSESSMENT.

Candidate's signature Date (Month/Day/Year)