

# OCCUPATIONAL FIRST AID MEDICAL CERTIFICATE OF FITNESS

## Report of Examining Physician

### EXAMINING PHYSICIAN PLEASE NOTE:

1. The fee for the services of the physician is the responsibility of the candidate.
2. It is essential that the candidate be PHYSICALLY AND PSYCHOLOGICALLY fit to perform the duties of an Occupational First Aid Attendant.

### PLEASE PRINT

Surname of candidate <i>Mr. Ms.</i> <i>Mrs. Miss</i>	Given names in full	Date of birth <i>Month Day Year</i>		
Mailing address	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 ( <i>not otherwise specified</i> )	<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

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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 \_\_\_\_\_

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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 \_\_\_\_\_

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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  No

If no, please explain \_\_\_\_\_

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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  No

If no, please explain \_\_\_\_\_

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**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 \_\_\_\_\_

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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 \_\_\_\_\_

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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 \_\_\_\_\_

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

If yes, please explain \_\_\_\_\_

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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  No

If no, please explain \_\_\_\_\_

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Physician's name <i>(please print)</i>	Physician's signature	Phone number <i>(please include area code)</i>	
Street address	City	Province	Postal code
Date  <i>Month                  Day                  Year</i>	Clinic or physician's stamp		

<b>Candidate's statement</b>	
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  <i>Month                  Day                  Year</i>