Medical Assessment Form For Firefighters Using Breathing Apparatus

IMPORTANT PLEASE READ: INFORMATION FOR DOCTORS & MEDICAL CENTRES

Once completed, please send this form with the invoice addressed to Fire and Emergency NZ to Volunteer Recruitment,
Email: screening@fireandemergency.nz Fax: 04 471 1793

All of the questions in this form for new volunteer recruits are relevant. We ask that every question on this form is answered fully and comprehensively. Please read the form carefully.

As an examining doctor, you must consider the tasks, physical environment and safety-critical nature of firefighting while undertaking this medical assessment, and ensure that the forms are completed in full and all relevant information is provided to Fire and Emergency New Zealand (NZ).

Firefighters perform functions that are physically and psychologically demanding. These functions are often performed in emergency situations, under difficult environmental conditions. Firefighters are also required to wear personal protective equipment, including structural firefighting ensemble and breathing apparatus. Any potential cause of sudden incapacity is clearly not compatible with this type of work. Firefighters require a level of medical fitness compatible with a class 2-5 licence.

The Fire and Emergency NZ National Medical Officer will ultimately be responsible for determining whether a new applicant is fit to become a volunteer firefighter. Please do not pre-empt this decision by offering an opinion regarding work fitness, as this can create confusion and delay the process, especially if this opinion is different from that of the National Medical Officer.

There are some situations where further medical assessments or tests are required before a decision can be made on work fitness. Fire and Emergency NZ will request these if required.

If you have any questions regarding the medical screening assessment process, please contact Volunteer Recruitment, who are based at Fire and Emergency NZ National Headquarters in Wellington on 04 496 3716.

INVOICING INFORMATION

• It is expected that this medical assessment can be completed within a double appointment. If this is not possible we would appreciate an itemised account.

Fire and Emergency NZ are predominantly a volunteer organisation with 85% of our workforce serving as volunteers to respond to emergencies in your community. This applicant is joining as a volunteer.

• Please attach the invoice to the medical assessment and send them together screening@fireandemergency.nz

• Payment can only be made once Fire and Emergency NZ receives a completed copy of this medical form. Please retain a copy on the patient's file.

• Additional tests will not be paid for unless they have been requested by Fire and Emergency NZ.

• Fire and Emergency NZ will not pay for incomplete medical assessments. Please ensure you answer every question and call us if you have any queries.

Medical Assessment Form For Firefighters Using Breathing Apparatus

SECTION A - *applicant to read and complete*

IMPORTANT PLEASE READ: INFORMATION FOR APPLICANTS

Please get this form completed and sent to Fire and Emergency New Zealand quickly – this will ensure your application to become a volunteer progresses. Ensure you read and sign page 2.

- Fire and Emergency New Zealand pays for the information we request on this form and any other information we request. If the Medical centre asks you to pay, request they send the invoice with your medical to:
  Email screening@fireandemergency.nz or fax 04 471 1793
- NHQ will notify you and your brigade leader of the outcome of your application, or if there are any issues which will cause delays
- Any updates from NHQ will be emailed to the personal email you provided when you first submitted your application online. Check your spam/junk folder in case our emails end up there.
- If you wear contact lenses, please bring them to the appointment with you.
- If you have any questions phone your volunteer recruitment team 04 496 3716
- If you have to travel from your hometown, for example, if you require a saline test, please ask your brigade leader for an Expense Claim Form for mileage reimbursement.

First Name _____ Last Name _____

Date of Birth (dd/mm/yyyy) _____ Gender _____

Postal Address _____

_____ Post Code _____

Contact Phone Numbers _____

Is this your usual Medical Centre/GP?

If you are not completing this medical assessment with your regular GP, what is the reason?

_____

Occupation _____ Brigade Applying to _____

Applicant NHI _____

SECTION A - *applicant to read and complete*

I declare that:

- The answers to all questions are true and correct.
- I have read all the questions and answers and the information which I have provided is full and complete.
- I have not withheld any information which might cause Fire and Emergency New Zealand to incorrectly assess my ability to complete the role for which I have applied.
- I understand that I could be discharged if I am engaged by Fire and Emergency New Zealand and it is later discovered that I withheld information and/or provided false information.
- I hereby authorise the National Medical Officer or other Fire and Emergency New Zealand authorised administrative staff to contact my General Practitioner if any information is required to process my application to join Fire and Emergency New Zealand.

I understand that:

- I am providing health information to Fire and Emergency New Zealand and authorising Fire and Emergency New Zealand to obtain health information from my representatives (such as my GeneralPractitioner).
- My health information will be used for the purpose of determining my recruitmentapplication.
- If my recruitment application is successful, Fire and Emergency New Zealand may use my health information in databases for health and safety risk management (including identification of significant hazards), baseline monitoring, and comparison against my future state of health. Recipients of my health information may include the brigade leader of any brigade of which I become a member.
- My health information will be treated in accordance with the Privacy Act 2020 and the Health Information Privacy Code 2020. I have the right to access, and to correct, my health information that is held by Fire and Emergency New Zealand.
- My health information will be retained for a period of 40 years after I exit from Fire and Emergency New Zealand.

Applicant's Signature _____ Date _____

SECTION B - *GP to complete*

Applicant NHI: _____

If the answer is Yes to any question below, please give all details of each instance in the panel provided on the next page, and attach relevant specialist letters.

PLEASE ANSWER ALL QUESTIONS.

1	Any health or medical issue that may affect the ability to carry out the tasks required for the position being applied for? *(Tasks include but are not limited to: Running, climbing, bending, crawling, heavy lifting, carrying, gripping, reaching, and the ability to work independently.)*	Yes ☐	No ☐
2	Been diagnosed as having a serious illness, such as cancer or leukaemia? *(Please provide specialist's reports)*	Yes ☐	No ☐
3	Had the need for any medication relating to physical, neurological or psychological impairment? *(e.g. respiratory medication)*	Yes ☐	No ☐
4	Asthma, including childhood or chronic cough? ***(If 'Yes' please complete the Asthma Questionnaire on page 8)***	Yes ☐	No ☐
5	Pneumothorax?	Yes ☐	No ☐
6	Active infections such as TB?	Yes ☐	No ☐
7	Sleep apnoea? *(If 'Yes' comment on hypersomnolence)*	Yes ☐	No ☐
8	Any heart or vascular condition which restricts fitness for work? *(Please provide any reviews or tests)*	Yes ☐	No ☐
9	Chest pain due to proven or suspected angina?	Yes ☐	No ☐
10	Heart attack or heart failure?	Yes ☐	No ☐
11	Heart valve defect?	Yes ☐	No ☐
12	High or low blood pressure?	Yes ☐	No ☐
13	Irregular heart rate? * *(If yes, please provide recent ECG if available)*	* Yes ☐	No ☐
14	Peripheral vascular disease?	Yes ☐	No ☐
15	Stroke or Transient Ischemic Attack?	Yes ☐	No ☐
16	Any problem affecting general strength or fitness?	Yes ☐	No ☐
17	Any amputation of a hand, foot or limb?	Yes ☐	No ☐
18	Arthritis or joint replacement?	Yes ☐	No ☐
19	Limb, back or neck condition?	Yes ☐	No ☐
20	Skull or jaw condition affecting ability to wear breathing apparatus?	Yes ☐	No ☐
21	Recurrent joint dislocation?	Yes ☐	No ☐
22	Epilepsy, fainting attacks, fits or seizures?	Yes ☐	No ☐

SECTION B continued - *GP to complete*

23	Intellectual impairment?	Yes ☐	No ☐
24	Brain or head injury/disease, concussion or migraines?	Yes ☐	No ☐
25	Significant bowel disorder?	Yes ☐	No ☐
26	Hernia? *(If yes, note date and if repaired)*	Yes ☐	No ☐
27	Disease of urinary tract?	Yes ☐	No ☐
28	Anaemia or condition causing increased bleeding?	Yes ☐	No ☐
29	Diabetes (type 1 ☐ or type 2 ☐), thyroid or another gland problem? ***Hypoglycaemic episodes*** Yes ☐ No ☐ ***HbA1c -***	Yes ☐	No ☐
30	Mental illness, clinical depression, anxiety state or psychotic episodes? ***(complete details on page 6)***	Yes ☐	No ☐
31	Substance abuse, or alcohol dependence or abuse? *(provide full details and reports)*	Yes ☐	No ☐
32	Hearing loss, need to wear hearing aids, or any problems with balance? *(please circle)*	Yes ☐	No ☐
33	Reduced vision or night blindness?	Yes ☐	No ☐
34	Any medications being taken?	Yes ☐	No ☐
35	Allergies?	Yes ☐	No ☐

If you answered YES to any questions above, provide all details.
Please include specialist reports.

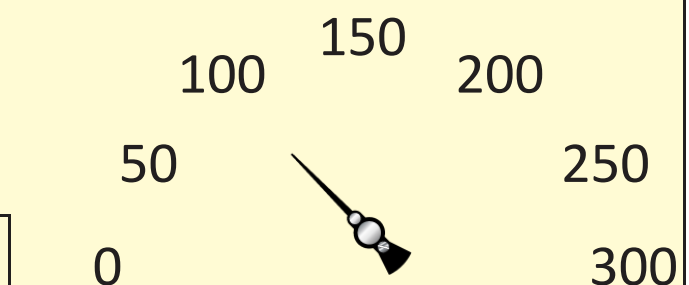
#	Cause	Treatment *(Please include specialist reports if available)*	Medications	Ongoing concerns, issues or limitations

SECTION C - *GP to complete*

PLEASE ANSWER ALL QUESTIONS. Please write your answer in the column to the right of the question.

1	Age	2 Height cm	3 Weight kg
4	BMI ***(If above 30, complete HbA1c or blood glucose (mmol/L)**		BMI= **BG/HbA1c=*
5	Pulse rate		reg/irreg
6	Any heart murmur or abnormal sounds? ***If yes, please describe murmur and provide any paperwork from investigation**		*Yes ☐ No ☐
7	Blood pressure ***If BP above 140/90 on first reading, please complete another BP recording 10 minutes apart.**		*BP= 2nd BP reading =
8	Is chest examination normal? ***(If no, please provide details)**		Yes ☐ *No ☐
9	Peak flow ***(Please coach patient in correct technique and repeat if lower than expected)*** ***If peak flow is >80 below expected for female or >100 below expected for male you must provide spirometry.***	Peak Flow L/min	Expected Peak Flow L/min
10	Spirometry ***(please attach full report)*** ***ONLY IF PEAK FLOW IS SUBOPTIMAL***		
11	Full range of movement is normal in upper and lower limbs? **If no, please provide details*		Yes ☐ *No ☐
12	Normal hearing to conversation? **(If no, please provide latest hearing test)*		Yes ☐ *No ☐

PLEASE ANSWER ALL QUESTIONS

13	Eyes – is the following normal? Visual Fields (more than 120°) at confrontation							Yes ☐		No ☐
14.1	**Distance Visual Acuity: (6m)** Standard-Uncorrected or with contacts 6/9 both eyes	**UNCORRECTED *(Mandatory)***			**GLASSES** *Please note: Glasses are incompatible with breathing apparatus*			**CONTACT LENSES**		
		Right	**Left**	**Both**	**Right**	**Left**	**Both**	**Right**	**Left**	**Both**
		6/	6/	6/	6/	6/	6/	6/	6/	6/
14.2	**Near Visual Acuity: (35cm)** Hold this paper 35cm away from the applicant (**without glasses**) and have them: • Read numbers at random • Identify where the gauge is Mark Y if able to identify numbers and gauge.	Uncorrected Both Eyes:	Y/N							

SECTION C continued – *GP to complete*

PSYCHOLOGICAL HISTORY

Psychiatric disorders can lead to sudden onset, which may present risks to the safety of the individual and others during firefighting and rescue work. The presence of psychological/neurological condition may not necessary preclude an applicant from entering Fire and Emergency New Zealand.

If there is any history of mental illness, please answer all questions below

Condition: please specify history, *warning signs and triggers*	**Triggers** ***(for initial depression and for any subsequent episodes)***	***List episodes, duration date and treatment eg. medication /counselling***
Episodes of psychosis? Yes ☐ No ☐ *If yes, please provide details and any related paperwork* ***PLEASE ATTACH SPECIALIST REPORTS***		
Anxiety? Yes ☐ No ☐ *If yes, please provide details: triggers, dates and duration of episode/s treatment (counselling, medication)* ***PLEASE ATTACH SPECIALIST REPORTS***		
Depression? Yes ☐ No ☐ *If yes, please provide details: triggers, dates and duration of episode/s treatment (counselling, medication)* ***PLEASE ATTACH SPECIALIST REPORTS***		

COVID-19 VACCINATION

Is the applicant vaccinated against COVID-19? Yes* ☐ No ☐

**If yes*, please provide the following details:*

Dose 1 ☐ Date: _____ Dose 2 ☐ Date: _____ Booster ☐ Date: _____

Type (please circle): Pfizer Janssen Moderna AstraZeneca

HEPATITIS & TETANUS

DO NOT VACCINATE OR PROCESS SEROLOGY FOR HEPATITIS OR TETANUS

Is the applicant vaccinated against Hepatitis A? Yes ☐ No ☐ Uncertain ☐

Is the applicant vaccinated against Hepatitis B? Yes ☐ No ☐ Uncertain ☐

Is the applicant vaccinated against Tetanus? Yes ☐ No ☐ Uncertain ☐

Please add any further comments you feel are necessary for Fire and Emergency New Zealand to know about this applicant for us to assess their entry into Fire and Emergency New Zealand.

SECTION D - *GP to complete*

Please email or fax all pages of this medical form and your invoice to Fire and Emergency New Zealand Volunteer Recruitment.

Email: screening@fireandemergency.nz Fax: 04 471 1793

If you have any medical queries, please phone Jane 04 496 3716 or Vanessa 04 498 5685

If you have any account queries, please phone 04 496 3666

Please note:

- ***Payment can only be made once Fire and Emergency New Zealand receives a completed copy of this Medical form. Please retain a copy on the patient's file.***
- ***Fire and Emergency New Zealand will not pay additional costs for any missing information, which should have been completed as part of the Medical Screening form.***
- ***Fire and Emergency New Zealand will not pay for any additional tests unless these have been requested by Fire and Emergency to assist with the recruitment process.***

I declare that all tests and information carried out on _____ are true and correct to the best of my knowledge.

GP's signature _____ Date _____

GP's name _____ Contact Number _____

Surgery Stamp:

PLEASE COMPLETE: CHECKLIST BEFORE SENDING

- ☐ **A copy of this medical has been saved to the patient's file.**
- ☐ **The medical assessment and invoice has been sent to Fire and Emergency New Zealand Volunteer Recruitment via email screening@fireandemergency.nz or fax 04 471 1793**
- ☐ **All questions have been answered**

GP to complete if any history of asthma, chronic cough or wheeze

ASTHMA QUESTIONNAIRE Please complete ONLY if the applicant has a history of asthma, including childhood asthma		
1	Age of onset	
2	When was the applicant's last asthma attack?	
3	Frequency, nature and severity of asthma symptoms	
4	Frequency of asthma symptoms requiring steroids	
5	Precipitating features:	
6	Current medication – including dosage and when last prescribed and used:	
7	Number of hospital admissions over the last 10 years for asthma	
8	**Peak flow/Spirometry results pre- and post-bronchodilator (if available in accordance with standards**	**Pre:** **Post:**
9	Date of last use of oral and or parental steroids	
GP COMMENTS		

FIRE AND EMERGENCY NZ WILL REFER APPLICANT FOR SALINE TESTING IF NECESSARY