WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

OCCUPATIONAL FIRST AID MEDICAL CERTIFICATE OF FITNESS

Report of Examining Physician

CERTIFICATION SERVICES
Phone 604 276-3090
Toll-free 1 888 621-7233, ext. 3090

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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	Given name(s) in full	Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐
Mailing address		Date of birth *(yyyy-mm-dd)*
City	Province	Postal code

1. **Disease conditions** — Is there MEDICAL EVIDENCE and/or a HISTORY of

Seizure disorder	Yes ☐	No ☐	Respiratory disease	Yes ☐	No ☐
Hernia	Yes ☐	No ☐	Heart disease	Yes ☐	No ☐
Communicable disease	Yes ☐	No ☐	Multiple sclerosis	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Other *(not otherwise specified)*	Yes ☐	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 PREVIOUS12 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 ☐ No ☐

   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 (i.e., is out of sight), 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)*

Surname of candidate	Given name(s)

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 lb. (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. **Medication** — Is the candidate taking any medication which could affect his/her ability to render first aid? Yes ☐ No ☐

   If yes, please explain

10. **Professional opinion** — 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

Physician's name *(please print)*	Physician's signature	Phone number *(include area code)*	
Street address	City	Province	Postal code
Date *(yyyy-mm-dd)*	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 *(yyyy-mm-dd)*