DISTRICT OF ELKFORD FIRE DEPARTMENT

ROUTINE DRIVER'S AND MEDICAL EXAMINATION REPORT

NAME OF FIREFIGHTER: _____
(SURNAME) (GIVEN NAMES)

ADDRESS: _____

DATE OF BIRTH: _____ **SOCIAL INSURANCE NO.:** _____
DAY MONTH YEAR

TELEPHONE NO.: _____ **JOB POSITION**: PAID-ON-CALL FIREFIGHTER

DRIVER'S LICENSE NO.: _____

CLASS NO.: __ **RESTRICTIONS:** _____

A. PHYSICAL EXAMINATION (To be completed by physician)

	Yes
VISION	
ACUITY LOSS	☐
FIELD DEFECT	☐
EYE DISEASE	☐
OTHER: _____	☐
MUSCULOSKELETAL	
AMPUTATION	☐
WEAKNESS	☐
RANGE OF MOTION LOSS	☐
OTHER: _____	☐
PSYCHIATRIC	
PSYCHOSIS	☐
SEVERE DEPRESSION	☐
IMPAIRED JUDGEMENT, INSIGHT	☐
MEDICATION NON-COMPLIANCE	☐
OTHER: _____	☐
CNS	
CVA/TIA DATE: _____	☐
SEIZURE DISORDER	☐
DATE LAST SEIZURE: _____	
NARCOLEPSY	☐
CONGENITAL CONDITION (CEREBRAL PALSY, ETC.)	☐
PROGRESSIVE DEFICIT (PARKINSON'S, MS, ALS, ETC.)	☐
STABLE DEFICIT (PARAPLEGIA, NERVE DAMAGE)	☐
COGNITIVE IMPAIRMENT	☐
MMSE SCORE: _____	
SIGNIFICANT HEAD INJURY	☐
OTHER: _____	☐
ENDOCRINE	
DIABETES	☐
INSULIN	☐
SIGNIFICANT HYPOGLYCEMIA	☐
DATE: _____	
HYPOGLYCEMIA UNAWARENESS	☐
HbA1C: _____	
DATE: _____	
OTHER: _____	☐

	Yes
HEARING	
HEARING LOSS	☐
VERTIGO	☐
EAR DISEASE	☐
OTHER: _____	☐
CARDIOVASCULAR	
SYNCOPE DATE: _____	☐
CAUSE: _____	
CAD (M.I., ANGIOPLASTY, CABG)	☐
DATE: _____	
ARRHYTHMIA	☐
PACEMAKER	☐
IMPLANTED DEFRIBRILLATOR	☐
CONGESTIVE HEART FAILURE	☐
ANEURYSM	☐
SITE: _____ SIZE: _____	
PERIPHERAL VASCULAR DISEASE	☐
OTHER: _____	☐
DRUGS AND ALCOHOL	
ALCOHOL OR DRUG ABUSE IN PAST 2 YEARS	☐
ALCOHOL RELATED SEIZURE	☐
ADDICTION REHAB	
TAKEN ☐ REFUSED ☐	
PRESCRIBED DRUGS THAT COULD IMPAIR	☐
PSYCHOACTIVE DRUGS	☐
NARCOTICS	☐
OTHER: _____	☐
RESPIRATORY	
HOME OXYGEN	☐
SLEEP APNEA	☐
EPWORTH SCORE: _____	
OTHER: _____	☐
OTHER CONDITIONS	
GENERAL DEBILITY OR FUNCTIONAL DECLINE	☐
OTHER: _____	☐

EXPLAIN FINDINGS: _____

_____

BLOOD PRESSURE READING: SYSTOLIC _____ DIASTOLIC _____

DISTRICT OF ELKFORD FIRE DEPARTMENT

ROUTINE DRIVER'S AND MEDICAL EXAMINATION REPORT

B. VISION SCREENING AND PHYSICAL FINDINGS AFFECTING DRIVING

Visual Acuity
☐ Uncorrected R _____ L _____ Both _____
☐ Corrected R _____ L _____ Both _____
VISUAL FIELD - - ☐ Normal ☐ Abnormal
Both visual acuity and visual field must meet Physician's Guide criteria for license class ☐ **YES**
Blood Pressure _____

C. OPINION

Having completed A & B as applicable, in your opinion, does the patient have a condition that may affect driving:

☐ No ☐ Yes ☐ May in Future – recommend follow-up in _____ years.

D. DETAILS OF CONDITION(S) THAT AFFECT OR MAY AFFECT DRIVING

_____
_____
_____

E. PHYSICIAN'S ASSESSMENT

Please elaborate on all positive results in Section A.

_____
_____
_____

Fire fighting is a very demanding profession. Firefighters are required to work under high heat and extremely stressful conditions in the performance of their duties and motor vehicle operation. **In your opinion is this individual mentally and physically fit for this job?**

Yes ☐ No ☐ (Explain if answered "No")

_____
_____

Family physician for _____ years. ☐ Locum ☐ Walk-in ☐ First Visit ☐ Specialist

PHYSICIAN'S NAME: _____ **SIGNATURE:** _____

ADDRESS: _____ **DATE**: _____

F. RECOMMENDATION(S)

☐ Special Consult – Type _____
Enclosed: ☐ Yes ☐ No I will arrange: ☐ Yes ☐ No

☐ Road test to assess _____

☐ Restrictions (Reason & Type) _____

G. RELEASE

In signing below, I authorize any licensed physician, medical practitioner, hospital, clinic, Superintendent of Motor Vehicles, or other medical or medically related facility that have any records or knowledge of the state of my health to release such information to the District of Elkford. I understand this information will be held in confidence by the Fire Chief and will only be used to determine my acceptance for firefighter duties.

_____ Date: _____
Signature of Firefighter