PRE-EMPLOYMENT MEDICAL EXAMINATION FORM
[MEDICAL PRACTITIONER/REGISTERED NURSE]

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Cardiovascular

Weight (kg):		Height (cm):	
BMI:		Blood Pressure:	/
Pulse & Character:			

Vision

	Uncorrected				Corrected			
Distance:	R		L		R		L	
Near:	R		L		R		L	
Intermediate:	R		L		R		L	
Colour:	Normal				Errors			
Peripheral:	R				L			

Respiratory *Alternatively attach lung function readout*

Spirometry	Initial Reading	Predicted for Age/Height
FEVI	%	%
FVC	%	%
FEV/FVC	%	%

Urinalysis

Protein		Sugar	

DRUG ANALYSIS

A urine sample is to be taken for drug screening purposes, if non-negative the ESR Chain of Custody form is to be completed and the sample and form sent to ESR for testing.

Musculoskeletal Assessment *full range of movement/flexibility*

			Comments
Shoulders:	Yes ☐	No ☐	
Elbows:	Yes ☐	No ☐	
Wrists:	Yes ☐	No ☐	
Hands:	Yes ☐	No ☐	
Hips:	Yes ☐	No ☐	
Knees:	Yes ☐	No ☐	
Ankles:	Yes ☐	No ☐	
Feet:	Yes ☐	No ☐	
Cervical Spine:	Yes ☐	No ☐	
Thoracic Spine:	Yes ☐	No ☐	
Lumbar Spine:	Yes ☐	No ☐	
Normal Co-ordination/Balance:	Yes ☐	No ☐	

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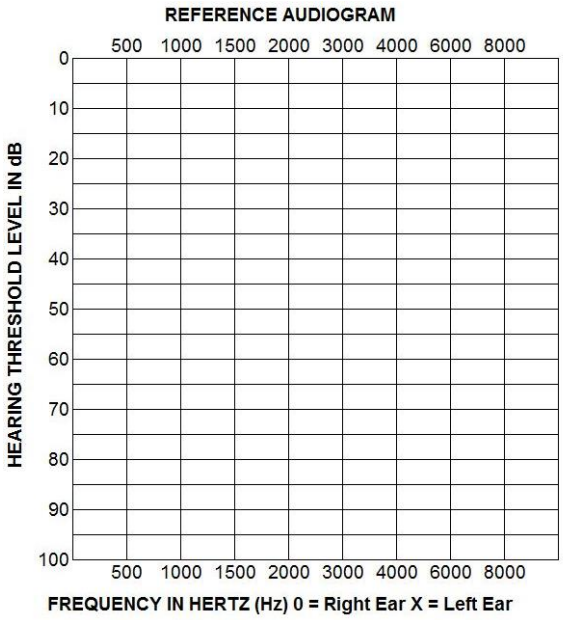
Audiogram – dB(A): OSH Standard

Noise Exposure History		Period Years/Months		Hearing Protectors	
Present Occupation:				Yes ☐	No ☐
Secondary Employment:				Yes ☐	No ☐
Previous Employment:	1.			Yes ☐	No ☐
	2.			Yes ☐	No ☐
	3.			Yes ☐	No ☐
Military Service:				Yes ☐	No ☐
Noisy Hobbies:				Yes ☐	No ☐
Comments					

First Assessment



Otoscopic Examination	Right Ear		Left Ear	
Canals Clear:	Yes ☐	No ☐	Yes ☐	No ☐
Normal Eardrum:	Yes ☐	No ☐	Yes ☐	No ☐
Any Perforation:	Yes ☐	No ☐	Yes ☐	No ☐
Comments:				

Health History

			Details
Diseases affecting hearing:	Yes ☐	No ☐	
Ear or head injuries:	Yes ☐	No ☐	
Family history of hearing loss:	Yes ☐	No ☐	
Recent earache or discharge:	Yes ☐	No ☐	
Any other health problems?	Yes ☐	No ☐	
Have you a hearing loss?	Yes ☐	No ☐	
Comments:			
Action to be taken:			

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General

Are there any functional limitations of the following systems or any condition increasing the risk to the worker or to co-workers?
Please tick and comment:

Use of Drug and Alcohol	☐	Communication	☐	Neurological	☐
Cardiovascular System	☐	Prescription Medications	☐	Locomotor/Musculoskeletal	☐
Abdomen/Hernia	☐	Respiratory and ENT System	☐		

COMMENTS	

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DECLARATION

Name of Candidate:			
Date of Birth:		Date of Request:	
Home Address:			
☐ I have sighted the Candidate's photo ID	Type: *(e.g. driver's license, passport, etc.)*		Number:

I certify that I have examined the Candidate named in accordance with McConnell Dowell's Pre-Employment Health Assessment Procedure and in my opinion the Candidate is *(tick appropriate box)*:

☐ **Fit for Duty** – Meets all relevant medical criteria	**I recommend:** Local doctor referral Conditional on corrective lenses Conditional on hearing aid Other condition (specify): _____
☐ **Fit for Duty Subject to Review** – Does not meet all medical criteria, but could perform safety work if the condition is sufficiently under control and worker is more frequently reviewed than prescribed under periodic review	**I recommend:** Review at this practice DATE: _____ Specialist referral Local doctor referral Laboratory tests This certificate is valid until: _____
☐ **Fit for Duty Subject to Job Modification** – Does not meet all medical criteria, but could perform current work if suitable modifications were made (e.g. manual handling)	**I recommend the following job modifications:** _____ _____ _____
☐ **Temporarily Unfit for Duty Subject to Review** – Does not meet all medical criteria and cannot perform current safety tasks, but may perform alternative tasks. May return to full duty pending improvement in condition, response to treatment, confirmed diagnosis of undifferentiated illness	**I recommend the following in terms of management and review:** _____ _____ _____
☐ **Permanently Unfit for Duty** – Does not meet the medical criteria and cannot perform the job in the future	**I recommend the following in terms of management and review:** _____ _____ _____

Drug and Alcohol Screen Results: _____

Additional Medical Results:
(attached as required)

- ☐ **Chest X-Ray** (with Radiologist Report)
- ☐ **ECG** (with Cardiologist Report)
- ☐ **Blood Tests** (for Cholesterol and Diabetes)

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Medical Practitioner/Registered Nurse Details *(stamp acceptable)*:

Name: _____ Phone/Fax: _____

Practice Address: _____

Signature: _____ Date: _____

Action(s) Taken as a result of Health Assessment

McConnell Dowell HR to complete on receipt of Assessment Report in conjunction with Recruiting Manager

☐ Job Modification *(details)*: _____

☐ Triggered Review *(indicate period)*: _____

☐ Periodic Health Assessment schedule *(details)*: _____

☐ Redeployment *(details)*: _____

☐ Drug Assessment *(details)*: _____