Employee: DOB: Date:

PHYSICAL FINDINGS

Height: cm	Weight: kg		Pulse: bpm	B.P. mmol/hg	
Vision: Without Glasses	20/ R	20/ L	With glasses	20/ R	20/ L
Peripheral	° R	° L	Colour Vision	Normal	Deficient

Was Ishihara done? Yes O No O Result:_____

Urinalysis	Specific Gravity:	Protein:	Glucose:	Blood:

If Glucose is positive on Dipstick, please provide glucometer reading: _____ mmol/L

Was Physical Demands Analysis attached/seen ? Yes O No O

Check under N if Normal or AB if abnormal and give details of any abnormal findings below in the physician/nurses comments:

	N	AB		N	AB		N	AB
General Appearance			Pharynx (inc. tonsils)			Neurological		
Hygiene			Neck (inc. thyroid)			Hernia		
Skin (inc. Scalp)			Scars			Spine & ROM		
Eyes			Lungs			Joints and Extremities		
Ears, External			Heart			Mouth (Teeth, Gums)		
Ears, Drums, Canals			Peripheral pulses			Varicose veins		
Nose			Abdomen			Lymph Glands		

EXAMINER'S COMMENTS:

MEDICAL ASSESSMENT

O Recommended for employment without restrictions.

O Recommended for employment with restriction(s)/limitation(s): _____

O Not recommended for position.

O Recommend for Follow up with Family Doctor/Specialist – Why?_____

_____ _____ _____

Date of Examination Examiner's Signature Examiner's Name (please print)

Employee: DOB: Date:

Section 3: Medical Assessment - To be completed by examiner

Height: cm	Weight: (kg)	BMI:	Pulse: bpm	B.P. #1: B.P. #2: B.P. #3: Note: At least 3 readings to confirm high: High is >140/90

Vision: Without Glasses	20/ R	20/ L	20/ Both	With glasses	20/ R	20/ L	20/ Both

Was Ishihara done? O Yes O No Result:

Peripheral	R	L	Colour Vision	Normal	Deficient
Urinalysis	Specific Gravity:		Protein:	Glucose:	Blood:

If Glucose is positive on Dipstick, please provide glucometer reading: _____ mmol/L

Check under N if Normal or AB if abnormal and provide relevant details of any abnormal findings in comment section.

	N	AB		N	AB
1. Ears: external, internal, drums, canal			6. Neurological: Romberg, heel and toe walking, upper & lower reflexes		
2. Nose and mouth			7. Cardiovascular; normal heart sounds, rhythm		
3. Pharynx: incl. tonsils, lymph glands			8. Skin: scalp, scars, rashes, eczema		
4. Lungs: air entry, lung sounds, chest wall expansion respiratory rate			9. Musculoskeletal: Neck, back, knees, ROM		
5. Abdomen: soft, non-distended? Note-Inguinal hernia assessment can only be carried out if clinically indicated and examinee provides consent.			10. Musculoskeletal: Shoulders, arms, elbows, wrists, hands, fingers , ROM		

EXAMINER'S COMMENTS:

Section 4: Medical Opinion –To be completed by Examiner

O Medically fit without restrictions at the time of the assessment.

O Medically Fit with the following restrictions/limitations at the time of the assessment:

O Fitness to be determined upon receipt of additional information from treating physician(s).

If applicable, the Examinee is required to wear: ☐ corrective eyewear ☐ hearing aids ☐ hearing protection

O Medically unfit at the time of the assessment.

Date of Examination | Examiner's Signature | Examiner's Name (please print)

DRIVERCHECK
Medical Testing & Assessments

Pulmonary Function Test Questionnaire

When Respirator User Screening Form Completed

Examinee Information		
Name:		Birthdate (dd/mm/yyyy):
Company/Location/Division:	Job Title/Position/Department:	
Identification Information:		Date of Examination (dd/mm/yyyy):
Address: street, city, province, postal code:		Telephone (Please indicate if home, cell, work): #1 #2

Ethnic background: Black ☐ Asian ☐ Hispanic ☐ Caucasian ☐ All others ☐ Gender: Male ☐ Female ☐

✓ See **Respiratory User Screening Form** for additional employee health history information.

Employee Health Conditions *Please indicate if you currently have, or have ever experienced any of the following*

☐ Do you wear dentures of partial plates?
☐ Do you use a Bronchodilator?
☐ Have you used a Bronchodilator today?
☐ Are you currently experiencing more than minor cold symptoms?
☐ Have you had surgery in the past month?
☐ Have you smoked any cigarettes, pipes, or cigars within the last hour?
☐ Have you eaten a large meal within the past hour?
☐ Have you been told you have high blood pressure?

Occupational and Non-Occupational Exposure History *Please Indicate if you have been exposed to any of the following*

☐ Cement/concrete	☐ Ionizing radiation	☐ Mercury	☐ Chromium
☐ Cotton Dust	☐ Coke oven emissions	☐ Isocyanates	☐ Cobalt
☐ Coal Dust	☐ Noise	☐ Benzene	☐ Iron
☐ Wood Dust	☐ Silica	☐ Cutting oil	☐ Lead
☐ Welding fumes	☐ Radioactive material	☐ Chemicals	☐ Nickel
☐ Arsenic	☐ Solvents/degreasers	☐ Fibreglass	☐ Tin
☐ Asbestos	☐ Acrylonitrile	☐ Other	☐ Other metals
☐ Pesticide/herbicide	☐ Ethylene Oxide	☐ Aluminum	
☐ Industrial gases/fumes	☐ Vinyl chloride	☐ Beryllium	

Exposure	Source	Period (Years)

I certify that the above information that I have provided is complete and true to the best if my knowledge.	
Examinee Signature:	Date (mm/dd/yyyy):

Pulmonary Function Test Questionnaire

When Respirator User Screening Form Completed

Examinee Name:

Examiner to complete.

Examinee Height: **Weight:** **Blood Pressure:** _____ **Systolic** _____ **Diastolic**

✓ If greater than 140/90 do not proceed with the test

Examiner Comments (If applicable):

Examiner Information

Examiner's name: _____

Examiner's signature: _____

Address: _____

_____

Telephone number: _____ Fax number: _____

- Upon completion, please fax the questionnaire and acknowledgement form ASAP to DriverCheck at 519-632-8238.
- For questions or concerns, please contact DriverCheck at 1-800-463-4310.
- Thank you for your assistance.

DRIVERCHECK
Medical Testing & Assessments

Respirator User Screening Form

For initial and periodic screening of respirator users in conjunction with CSA Z94.4, Clause 12

Name (Print):	Birthdate month/day/year	Exam Date:
Address:	Ph #	Ph #
Company/ Location/Division:	Job Title/Position/Department:	

Age:	Height:	Weight:	Gender: Male ☐ Female ☐

EMPLOYEE HEALTH CONDITIONS

Do you have allergies? Yes ☐ No ☐
If you have allergies, do your allergic reactions interfere with your breathing? Yes ☐ No ☐

Have you used a respirator previously? Yes ☐ No ☐ If yes, what type(s)
_____

If you've used a respirator previously, has its use caused any of the following problems?
☐ Eye irritation ☐ Skin allergies or rashes ☐ Anxiety that occurs only when you use the respirator ☐ Unusual weakness or fatigue

☐ Any other problem that interferes with your use of a respirator

Have you ever experienced difficulties with fitting a respirator previously? Yes ☐ No ☐

Do you have any concerns about your future ability to use a respirator safely? Yes ☐ No ☐

Smoking History

Do you smoke? Yes ☐ No ☐
If yes, how much do you smoke?_____ For how Long?_____

Are you an ex-smoker? Yes ☐ No ☐
If yes, how long did you smoke for?_____
Quit Date_____ Method of quitting_____

Are you currently, or have been exposed to second hand smoke? Yes ☐ No ☐

Respiratory History *Please indicate if you currently have, or have ever experienced any of the following*

☐ Chronic cough
☐ Chronic bronchitis
☐ Sputum (excessive)
☐ Wheeze
☐ Shortness of breath
☐ Collapsed lung
☐ Broken rib(s)
☐ Tuberculosis
☐ Pneumonia
☐ Asthma
☐ Emphysema

Cardiac History *Please indicate if you currently have, or have ever experienced any of the following*

☐ Heart trouble
☐ High blood pressure
☐ Murmurs
☐ Swelling to hands/feet
☐ Rheumatic fever
☐ Chest pain on exertion
☐ Pacemaker

Other *Please indicate if you currently have, or have ever experienced any of the following*

☐ Neuromuscular disease
☐ Temperature susceptibility
☐ Panic attacks
☐ Vision impairment
☐ Hearing impairment
☐ Fainting spells
☐ Back/Neck problems
☐ Colour blindness
☐ Reduced sense of smell
☐ Reduced sense of taste
☐ Dizziness/Nausea
☐ Thyroid problems
☐ Diabetes
☐ Dentures
☐ Seizures
☐ Claustrophobia/Fear of heights
☐ Unusual facial features/Skin conditions

Are you currently taking any medications? Please list: _____

Respirator User Screening Form

Examinee Name:

For initial and periodic screening of respirator users in conjunction with CSA Z94.4, Clause 12

CONDITIONS OF USE Examinee to complete.

What activities will be performed while wearing the respirator? (E.g. hands only, hands and arms, whole body, light work, moderate work, very heavy lifting, climbing, etc.). Explain:

To what extent will the respirator be used?

Frequency of respirator use:	☐Daily	☐Weekly	☐Monthly	☐Yearly	☐Other
Exertion level during use:	☐Light	☐Moderate	☐Heavy	☐Other:	
Duration of respirator use per shift:	☐<1/4 hr	☐>1/4 hr	☐>2 hr	☐Variable	☐Uncertain
Temperature during use:	☐<0˚C	☐0-25˚C	☐>25˚C		
Atmospheric pressure:	☐Reduced	☐Normal/ambient	☐Increased		

SPECIAL WORK CONSIDERATIONS Examinee to complete.

Do you have special responsibilities for the safety of others (e.g. rescue worker, firefighter, security officer)? Yes ☐ No ☐

Uncontrolled hostile environment: check all that apply

☐Emergency escape	☐Rescue operations	☐Oxygen deficiency	☐Hazardous materials (emergency)
☐Fire fighting	☐IDLH	☐Confined spaces	☐Heights
☐Other:			

SPECIAL WORK CONSIDERATIONS Cont'd.

Other personal protective equipment:

Will you be using any of the following items with your respirator(s)? ☐HEPA Filters ☐Canisters ☐Cartridges

What other protective equipment will be worn or carried while the respirator is being used? Describe:

Estimated total weight of tools/equipment carried during respirator use: Average_____ Maximum

I certify that the above information that I have provided is complete and true to the best if my knowledge.	
Examinee Signature:	Date (mm/dd/yyyy):

PRIMARY ASSESSMENT: Examiner's opinion on examinee fitness to wear a respirator.

Respirator use permitted: Yes ☐ No☐ Uncertain ☐

☐ I recommend follow-up medical evaluations on a yearly basis

Referred to medical assessment: Yes ☐ No☐

Comments:

FIT TESTING RESULTS

Method Used: Qualitative ☐ Quantitative ☐

Mask Make/Model:	Size:	Mask Make/Model:	Size:
Mask Make/Model:	Size:	Mask Make/Model:	Size:
Mask Make/Model:	Size:	Mask Make/Model:	Size:

Examiner Name (print): _____

Signature: _____ Date: _____

Address: _____

Telephone number: _____ Fax number: _____

DRIVERCHECK
Medical Testing & Assessments

Examinee Information	
Name:	Birthdate (dd/mm/yyyy)
Company/ Location/Division:	Job Title/Position/Department:

KRAUS-WEBER STRENGTH AND FLEXIBILITY RATING (MODIFIED)		
DESCRIPTION	TEST	RATING
LIE ON YOUR BACK, HANDS AT YOUR EARS, LEGS STRAIGHT RAISE BOTH FEET 10 INCHES OFF THE FLOOR, AND HOLD FOR 10 SECONDS. FULL MARKS IF ABLE TO KEEP LOWER BACK FLAT TO FLOOR	HIP FLEXORS	
LIE ON YOUR BACK, HANDS AT YOUR EARS, FEET HELD BY EXAMINER. TRY TO "ROLL" UP TO A SITTING POSITION.	ABDOMINAL AND HIP FLEXORS	
LIE ON YOUR BACK, HANDS AT YOUR EARS, KNEES FLEXED, FEET HELD BY EXAMINER. TRY TO "ROLL" TO A SITTING POSITION.	ABDOMINALS	
LIE ON YOUR STOMACH, HANDS BEHIND NECK. WITH SOMEONE HOLDING YOUR FEET AND HIPS DOWN, RAISE YOUR TRUNK AND HOLD FOR 10 SECONDS	UPPER BACK MUSCLES	
LIE ON YOUR STOMACH, HANDS BEHIND NECK. WITH SOMEONE HOLDING YOUR SHOULDERS DOWN, RAISE LEGS AND HOLD FOR 10 SECONDS.	LOWER BACK MUSCLES	
STAND ERECT, KNEES STIFF, HANDS AT SIDES. TRY TO TOUCH FLOOR WITH FINGER TIPS.	FLEXIBILITY AND MUSCLE TENSION	
WITH BACK STRAIGHT, BEND KNEES AND ROCK FORWARD ONTO TOES AND HOLD FOR 10 SECONDS.	QUADRICEPS AND BALANCE	
TAL:		/70

DEGREE OF FLEXIBILITY IS RATED FROM 1-10 BASED ON FLEXION OR ABILITY TO MAINTAIN POSITION FOR UP TO 10 SECONDS.

MAXIMUM = 70 SATISFACTORY = 60

SCORE OF THE KRAUS-WEBER BACK STRENGTH AND FLEXIBILITY RATING MUST BE CONSIDERED AS ONE PORTION OF THE TOTAL DATA COMPILED DURING THE PRE-EMPLOYMENT HEALTH SCREENING. ALL INFORMATION MUST BE CONSIDERED AND WEIGHED WHEN MAKING RECOMMENDATIONS OR APPLYING RESTRICTIONS.

Medical Examiner Comments

Medical Examiner Information		
Name:	Signature:	Date (mm/dd/yyyy)

DRIVERCHECK PHYSICAL EXAMINATION FOR TRANS-BORDER DRIVERS

This form in no way replaces any government licensing form.

DRIVER CHECK

1. DRIVER'S INFORMATION Driver completes this section.

COMPANY: ORDER #:

Driver's Name (Last, First, Middle)	Social Insurance Number	Birthdate (MONTH / DAY / YEAR)	Age	Sex ☐M ☐F	☐New Certification ☐Recertification ☐Follow Up	Date of Exam (MONTH / DAY / YEAR)
Address	Work Tel: ( )	Driver Licence Number				
City, Province, Postal Code	Home Tel: ( )					

1. Retain copy in physician's file.
2. Give original to driver or to driver's employer.

2. HEALTH HISTORY Driver completes this section, but medical examiner is encouraged to discuss with driver.

YES	NO	
☐	☐	Any illness or injury in last 5 years?
☐	☐	Head/Brain injuries, disorders or illnesses
☐	☐	Seizures, epilepsy ☐ medication _____
☐	☐	Eye disorders or impaired vision (except corrective lenses)
☐	☐	Ear disorders, loss of hearing or balance
☐	☐	Heart disease or heart attack: other cardiovascular condition ☐ medication _____
☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)
☐	☐	High blood pressure ☐ medication _____
☐	☐	Muscular disease

YES	NO	
☐	☐	Shortness of breath
☐	☐	Lung disease, emphysema, asthma, chronic bronchitis
☐	☐	Kidney disease, dialysis
☐	☐	Liver disease
☐	☐	Digestive problems
☐	☐	Diabetes or elevated blood sugar controlled by: ☐ diet ☐ pills ☐ insulin
☐	☐	Nervous or psychiatric disorders, e.g., severe depression ☐ medication _____
☐	☐	Loss of, or altered consciousness

YES	NO	
☐	☐	Fainting, dizziness
☐	☐	Sleep disorders, pauses in breathing while asleep, sleep apnea, daytime sleepiness, loud snoring
☐	☐	Stroke or paralysis
☐	☐	Missing or impaired hand, arm, foot, leg, finger, toe
☐	☐	Spinal injury or disease
☐	☐	Chronic low back pain
☐	☐	Regular, frequent alcohol use
☐	☐	Narcotic or habit forming drug use

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's certification.

Driver's Signature: X Date:

Medical Examiner's Comments on Health History (The medical examiner must review and discuss with the driver any "yes" answers and potential hazards of medications, including over-the-counter medications, while driving.)

3. VISION Medical Examiner completes this section.

Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° peripheral in horizontal meridian measured in each eye. **Monocular drivers are not trans-border qualified.**

Instructions: *If applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious.*

NUMERICAL READINGS MUST BE PROVIDED			
Acuity	**Uncorrected**	**Corrected**	**Horizontal Field of Vision**
Right Eye	20/	20/	Right Eye °
Left Eye	20/	20/	Left Eye °
Both Eyes	20/	20/	°

Can applicant recognize and distinguish among traffic control signals and devices showing standard red, green and amber colours? ☐ Yes ☐ No

Applicant meets visual acuity requirement only when wearing: ☐ Corrective lenses Monocular vision: ☐ Yes ☐ No

Complete only if vision testing is done by an ophthalmologist or optometrist

Name of Ophthalmologist/Optometrist (Print) Tel. No. ( )

Date of Examination | Licence No./Province of Issue | Signature

4. HEARING Medical Examiner completes this section.

☐ Check if hearing aid used for tests ☐ Check if hearing aid required to meet standard.

Standard: a) Must first perceive forced whispered voice in the better ear at not less than 5 feet, with or without hearing aid, or
b) If audiometer used, does not have an average hearing loss in the better ear greater than 40 dB at 500 Hz, 1000 Hz, and 2000 Hz with or without a hearing aid when the device is calibrated to ANSI Z24.5-1951. *To average, add the readings for 3 frequencies tested and divide by 3.*

NUMERICAL READINGS MUST BE RECORDED
a) Record distance from individual at which forced whispered voice can first be heard.
Right Ear (Feet) Left Ear (Feet)

b) If audiometer is used, record hearing loss in decibels (according to ANSI Z24.5-1951).

Right Ear: 500 Hz	1000 Hz	2000 Hz	Left Ear: 500 Hz	1000 Hz	2000 Hz
Average:			Average:		

DRIVERCHECK OCCUPATIONAL HEALTH EXAMINATION FOR SAFETY SENSITIVE POSITIONS

DRIVER CHECK

D951267

SPECIMEN ID NO. A

PLACE OVER CAP

1. APPLICANT'S/EMPLOYEE'S INFORMATION – Applicant

Applicant's Name (Last, First, Middle)		Age	Sex ☐M ☐F	☐New Certification ☐Recertification ☐Follow Up	Date of Exam (MONTH / DAY / YEAR)
Address	Work Tel: ( )	Driver's Licence Number			1. Retain copy in physician's file. 2. Give original to applicant or to applicant's employer
City, Province, Postal Code	Home Tel: ( )				

2. HEALTH HISTORY – Applicant completes this section, but medical examiner is encouraged to discuss with applicant.

YES	NO	
☐	☐	Any illness or injury in last 5 years?
☐	☐	Head/Brain injuries, disorders or illnesses
☐	☐	Seizure free for 5 years on or off medication(s)
☐	☐	Eye disorders or impaired vision (except corrective lenses)
☐	☐	Ear disorders, loss of hearing or balance
☐	☐	Heart disease or heart attack: other cardiovascular condition ☐ medication _____
☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)
☐	☐	High blood pressure ☐ medication _____
☐	☐	Muscular disease
☐	☐	Shortness of breath
☐	☐	Lung disease, emphysema, asthma, chronic bronchitis
☐	☐	Kidney disease, dialysis
☐	☐	Liver disease
☐	☐	Digestive problems
☐	☐	Diabetes or elevated blood sugar controlled by: ☐ diet ☐ pills ☐ insulin
☐	☐	Nervous or psychiatric disorders, e.g., severe depression ☐ medication _____
☐	☐	Loss of, or altered consciousness
☐	☐	Fainting, dizziness
☐	☐	Sleep disorders, pauses in breathing while asleep, sleep apnea, daytime sleepiness, loud snoring
☐	☐	Stroke or paralysis
☐	☐	Missing or impaired hand, arm, foot, leg, finger, toe
☐	☐	Spinal injury or disease
☐	☐	Chronic low back pain ☐ medication _____
☐	☐	Regular, frequent alcohol use
☐	☐	Narcotic or habit forming drug use

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitations. List all medications (including over-the-counter medications) used regularly or recently.

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's certification.

Applicant's Signature: X **Date:**

Medical Examiner's Comments on Health History (The medical examiner must review and discuss with the applicant any "yes" answers and potential hazards of medications, including over-the-counter medications, while working.)

3. VISION – Medical Examiner completes this section.

Standard: 1) Not less than 20/40 with both eyes open and examined together. Worse eye not less than 20/200; 2) 120 continuous degrees along horizontal meridian and 15 continuous degrees above and below fixation with both eyes open and examined together.

Instructions: *If applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the applicant habitually wears contact lenses, or intends to do so while working, sufficient evidence of good tolerance and adaptation to their use must be obvious.*

NUMERICAL READINGS MUST BE PROVIDED			
Acuity	**Uncorrected**	**Corrected**	**Horizontal Field of Vision**
Right Eye	20/	20/	Right Eye °
Left Eye	20/	20/	Left Eye °
Both Eyes	20/	20/	°

Can applicant recognize and distinguish among traffic control signals and devices showing standard red, green and amber colours? ☐ Yes ☐ No

Applicant meets visual acuity requirement only when wearing: ☐ Corrective lenses

Complete only if vision testing is done by an ophthalmologist or optometrist

Name of Ophthalmologist/Optometrist (Print)		Tel. No. ( )
Date of Examination	Licence No./Province of Issue	Signature

4. HEARING – Medical Examiner completes this section.

☐ Check if hearing aid used for tests ☐ Check if hearing aid required to meet standard.

Standard: a) Must first perceive forced whispered voice in the better ear at not less than 5 feet, with or without hearing aid, or
b) If audiometer used, does not have an average hearing loss in the better ear greater than 40 dB at 500 Hz, 1000 Hz, and 2000 Hz with or without a hearing aid when the device is calibrated to ANSI Z24.5-1951. *To average, add the readings for 3 frequencies tested and divide by 3.*

NUMERICAL READINGS MUST BE RECORDED			
a) Record distance from individual at which forced whispered voice can first be heard.			
Right Ear	(Feet)	Left Ear	(Feet)

b) If audiometer is used, record hearing loss in decibels (according to ANSI Z24.5-1951).					
Right Ear: 500 Hz	1000 Hz	2000 Hz	Left Ear: 500 Hz	1000 Hz	2000 Hz
Average:			Average:		

5. BLOOD PRESSURE/PULSE RATE Medical Examiner completes this section.

Medical Examiner should take at least 2 readings to confirm high blood pressure, and where applicable should consider use of a large cuff.

	Systolic	Diastolic
Blood Pressure		

Driver qualified for 2 years if <140/90.

Pulse Rate ☐ Regular ☐ Irregular

GUIDELINES FOR BLOOD PRESSURE EVALUATION			
READING	CATEGORY	EXPIRATION DATE	RECERTIFICATION
140-159/90-99	Stage 1	1 year	For 1 year if <140/90 One-time certificate for 3 months if 140-159/90-99
160-179/100-109	Stage 2	One-time certificate for 3 months	For 1 year from date of initial exam if <140/90
≥180/110	Stage 3	Disqualified until BP <140/90	For 6 months if <140/90 and every 6 months thereafter

6. LABORATORY AND OTHER TEST FINDINGS. Medical Examiner completes this section.

Numerical readings must be recorded.

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

URINE SPECIMEN	Sp. Gr.	Protein	Blood	Sugar	

Other Testing: (Describe and record)

7. PHYSICAL EXAMINATION Medical Examiner completes this section.

Height: _____ Weight: _____

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen or is readily amenable to treatment. Even if a condition does not disqualify a driver, the medical examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible particularly if the condition, if neglected, could result in more serious illness that might affect driving. **Attention: A diagnosis of epilepsy or insulin-controlled diabetes disqualifies a driver.**

Check YES if there are any abnormalities. Check NO if the body system is normal. Discuss any YES answers in detail in the space below, and indicate whether it would affect the driver's ability to operate a commercial motor vehicle safely. Enter applicable item number before each comment. If organic disease is present, note that it has been compensated for. See *Instructions to the Medical Examiner* for guidance.

BODY SYSTEM	CHECK FOR:	YES*	NO
1. General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.	☐	☐
2. Eyes	Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos, strabismus uncorrected by corrective lenses, retinopathy, cataracts, aphakia, glaucoma, macular degeneration.	☐	☐
3. Ears	Middle ear disease, occlusion of external canal, perforated eardrums.	☐	☐
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing.	☐	☐
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker.	☐	☐
6. Lungs and chest, not including breast examination	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory function, dyspnea, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/or x-ray of chest.	☐	☐
7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness.	☐	☐
8. Vascular System	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.	☐	☐
9. Genito-urinary System	Hernias.	☐	☐
10. Extremities - Limb impaired. Driver may be subject to limb waiver if otherwise qualified.	Loss or impairment of leg, foot, toe, arm, hand, finger. Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly.	☐	☐
11. Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.	☐	☐
12. Neurological	Impaired equilibrium, coordination or speech pattern; paresthesia, asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia.	☐	☐

* COMMENTS: _____

8. CERTIFICATION STATUS Medical Examiner completes this section.

I certify that I have examined (print) _____ and based on the information obtained in this assessment, I find him/her medically qualified to operate a commercial motor vehicle. A completed examination form for this person is on file in my office.

If applicable, this person is qualified only when:

☐ wearing corrective lenses ☐ wearing hearing aid

Qualification expires on: _____

☐ Currently meets standards; qualifies for 2 year certificate.

☐ Does not meet standards.

☐ Meets standards, but periodic evaluation required.
Due to _____ driver qualified only for:
☐ 3 months ☐ 6 months ☐ 1 year ☐ other

☐ Temporarily disqualified due to (condition or medication): _____
Return to medical examiner's office for follow up on _____

If driver meets standards, complete a Medical Examiner's Qualification Card.
For questions, call 1-800-463-4310.

ATTENTION
Use of any of the following is automatically disqualifying:
Implantable Cardioverter-Defibrillator (ICD)
Methadone
Insulin
Champix/Chantix

MEDICAL EXAMINER/REGISTERED NURSE

Name _____

Address _____

Phone _____

Licence No.: _____

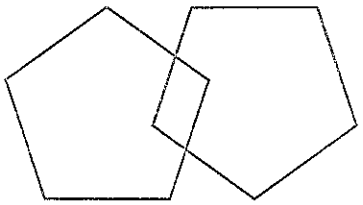
MEDICAL EXAMINER'S SIGNATURE

_____

The Mini-Mental State Exam

Patient_____ Examiner _____ Date_____

Maximum	Score	
		Orientation
5	( )	What is the (year) (season) (date) (day) (month)?
5	( )	Where are we (state) (country) (town) (hospital) (floor)?
		Registration
3	( )	Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Count trials and record. Trials _____
		Attention and Calculation
5	( )	Serial 7's. 1 point for each correct answer. Stop after 5 answers. Alternatively spell "world" backward.
		Recall
3	( )	Ask for the 3 objects repeated above. Give 1 point for each correct answer.
		Language
2	( )	Name a pencil and watch.
1	( )	Repeat the following "No ifs, ands, or buts"
3	( )	Follow a 3-stage command: "Take a paper in your hand, fold it in half, and put it on the floor."
1	( )	Read and obey the following: CLOSE YOUR EYES
1	( )	Write a sentence.
1	( )	Copy the design shown.



_____ Total Score

ASSESS level of consciousness along a continuum _____

Alert Drowsy Stupor Coma

"MINI-MENTAL STATE." A PRACTICAL METHOD FOR GRADING THE COGNITIVE STATE OF PATIENTS FOR THE CLINICIAN. *Journal of Psychiatric Research*, 12(3): 189-198, 1975. Used by permission.

try this: Best Practices in Nursing Care to Older Adults

A series provided by
The Hartford Institute for Geriatric Nursing
(hartford.ign@nyu.edu)
www.hartfordign.org

MONTREAL COGNITIVE ASSESSMENT (MOCA)

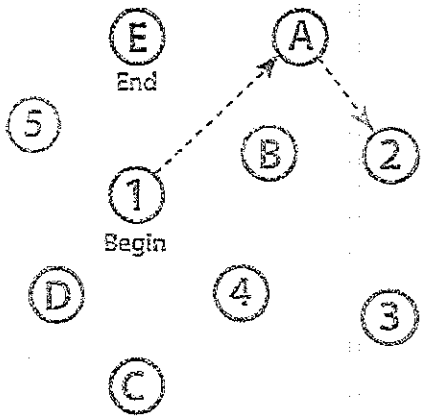
Version 7.1 Original Version

NAME :

Education : Date of birth :

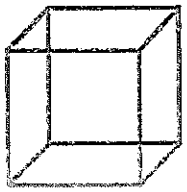
Sex : DATE :

VISUOSPATIAL / EXECUTIVE



[ ]

Copy cube



[ ]

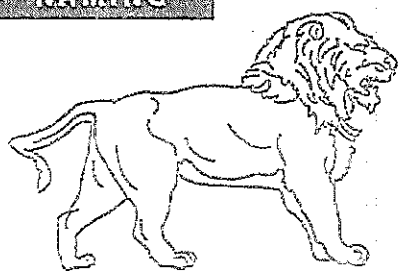
Draw CLOCK (Ten past eleven)
(3 points)

[ ] Contour [ ] Numbers [ ] Hands

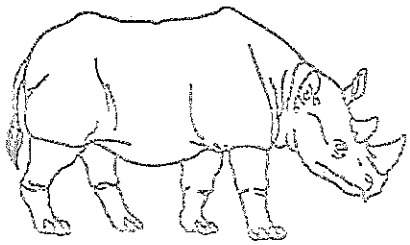
POINTS

___/5

NAMING



[ ]



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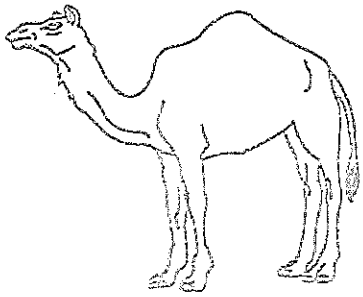

[ ]

___/3

MEMORY

Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial					
2nd trial					

No points

ATTENTION

Read list of digits (1 digit/ sec.).

Subject has to repeat them in the forward order [ ] 2 1 8 5 4

Subject has to repeat them in the backward order [ ] 7 4 2

___/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors

[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

___/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65

4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt

___/3

LANGUAGE

Repeat : I only know that John is the one to help today. [ ]

The cat always hid under the couch when dogs were in the room. [ ]

___/2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] _____ (N ≥ 11 words)

___/1

ABSTRACTION

Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler

___/2

DELAYED RECALL

	Has to recall words WITH NO CUE	FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only
Optional	Category cue						
	Multiple choice cue						

___/5

ORIENTATION

[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City

___/6

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www.mocatest.org

Normal ≥26 / 30

TOTAL ___/30

Add 1 point if ≤12 yr edu

Administered by: _____

Company:
Employee:

Titmus Orthorator

☐ Glasses ☐ Contact Lenses ☐ Both ☐ None ☐ Bifocal ☐ Trifocal ☐ Reading

Comments_____

Far Point (20FT.) Test

1 Binoc. Vision 2 Cubes 3 Cubes 4 Cubes	Corrected / Uncorrected														Score
Target	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
2 Both Eyes	T	R	R	L	T	B	L	R	L	B	R	B	T	R	20/
3 Right	T	L	T	T	B	B	L	B	R	T	R	L	B	R	20/
4 Left	L	R	L	B	R	T	T	B	R	T	B	R	T	L	20/
Snellen Equivalents	20/200	20/100	20/70	20/50	20/40	20/35	20/30	20/25	20/22	20/20	20/18	20/17	20/15	20/13	
5 Stereo Depth			1 B	2 L	3 B	4 T	5 T	6 L	7 R	8 L	9 R				/ 9
6 Color	A 12		B 5		C 26		D 6		E 16	F 0					/ 6
7 Vertical	1		2		3		4		5	6			7		
8 Lateral	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15														

Near Point 14 in.

1 Binoc. Vision 2 Cubes 3 Cubes 4 Cubes	Corrected / Uncorrected														Score
Target	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
2 Both Eyes	T	R	R	L	T	B	L	R	L	B	R	B	T	R	20/
3 Right	T	L	T	T	B	B	L	B	R	T	R	L	B	R	20/
4 Left	L	R	L	B	R	T	T	B	R	T	B	R	T	L	20/
Snellen Equivalents	20/200	20/100	20/70	20/50	20/40	20/35	20/30	20/25	20/22	20/20	20/18	20/17	20/15	20/13	

Was Ishihara done? Yes ☐ No ☐ Result: _____

Perimeter Right Temporal 85° 75° 55° Nasal 45° Total_____°

Left Temporal 85° 75° 55° Nasal 45° Total_____°

TECHNICIAN:_____

STANDARD HEARING TEST FORM

Company Name: _____

First Name : _____ Last Name: _____

Employee I.D. #: _____ (Male/Female):_____

Department : _____

Birth Date : (month)_____ (day)_____ (year)_____

Hire Date : (month)_____ (day)_____ (year)_____

I understand that my employer has requested this test to be conducted and may receive a copy of the results

Employee Signature: _____ Date: _____

How often do you wear hearing protection?

__Never __Rarely __Sometimes __Often __Very Often __Always __If Required __Not Required

What type of hearing protection do you most often wear?

__Plugs __Muffs __Both Together

Have you RECENTLY had the following:
(where necessary, please indicate which ear)

___Ear pain
___Ear drainage
___Dizziness
___Allergies
___Head cold
___Severe ringing in ear
___Sudden hearing loss
___Fluctuating hearing loss
___Fullness in ear
___Prescription medication

Have you EVER had any of the following:
(where necessary, please indicate which ear)

___Ear surgery
___Unconsciousness
___Seen specialist
___Hearing aid use
___Mumps
___Noisy hobbies
___Military service
___Firearm use
___Loud music
___Measles

OFFICE USE ONLY

	0.5kHz	1kHz	2kHz	3kHz	4kHz	6kHz	8kHz
LEFT							
RIGHT							

Audiometer (make/model):_____ Serial #:_____ Calibration Date:_____

OCCUPATIONAL HEALTH ASSESSMENT FOLLOW-UP

Employee Name: _____ **Date:** _____

Company Name: _____

Employee Instructions: Please have your treating physician complete this form and return to:

TREATING PHYSICIAN INSTRUCTIONS: Your patient completed a medical assessment at Workplace Medical Corp. for employment purposes to assess their ability to safely work as a _____ which is safety sensitive and/or physically demanding. During the medical assessment, we have the following findings:

_____

Refer to enclose results (if applicable).

☐ We are advising you of these medical issues and recommend you follow-up with your treating physician. We do not require any information.

In order to complete our assessment, we require:

☐ **Additional Information or follow-up with your treating physician. Please provide our office with the following information :**	○ Vision Deficiencies: A vision screen was conducted with the following results: 20/____ in the right eye and 20/____ in the left eye. To meet criteria, we require 20/40 in the better eye. Please have your Optometrist to assess you and update your prescription. Once completed, call WMC to rebook vision screen with corrective lenses ○ Respiratory: A Pulmonary function test (PFT) exam was completed with abnormal results. In order to wear a respirator safely, the minimum standard is FEV: 70%, FEV1: 70% and FEV/FEV1: 80%. A restriction of "no respirator use at this time" has been noted until such time minimum pulmonary function standards have been achieved. A referral to a Respirologist may be required. ○ Blood Pressure: Abnormal blood pressure was observed during the recent assessment. Readings in excess of 140/90 were observed. We require the patient to be assessed by their treating physician and provide 3 separate BP readings over 3 different days. ○ Metabolic/Diabetic issues: Blood sugar reading was abnormal (i.e. > 8). Please provide recent results of a HgA1c blood test, list of medications, and treatment plan details. ○ Hernia: An inguinal hernia was observed. A restriction has been placed until such time the patient is assessed and details of treatment plan are provided. ○ Mental Health/Additions: Please provide details of the treatment plan and list of medications. ○ Cardiac Issues: Please provide details of treatment plan, cardiologist reports and list of medications. ○ Musculoskeletal: Please provide details of treatment plan, specialist reports and any diagnostic tests. ○ Other:
☐ **Declaration by you**	"This patient is under my medical care and I am aware of the above mentioned finding(s). The patients is being appropriately treated and I believe this patient ☐ can or ☐ cannot safely conduct their job. (check one box) Treating physician's signature: _____ Print Name: Date:

Consent Form

(Medical Examinations and Medical Testing)

I understand that:

- My employer has requested and paid to have a medical assessment completed by&
- The results of this occupational medical assessment may be used by my employer to determine my fitness and/or ability to perform my employment duties.
- I am not, in any way, being treated by&

I have read and understood the above. I have been given an opportunity to ask questions.

Date	Employee Name (print)
Staff Witness	Employee Signature