Fire Crew Medical Examination

B C Forest Service Protection Program
2nd Floor, 2957Jutland Rd
Victoria B.C. V8W 3E7
Tel: (250) 387-5965 Fax: (250) 387-5685

- **All costs associated with obtaining this medical certificate will be the responsibility of the applicant.**
- **The medical examination report is only required at the pre-employment test, not at time of initial application. Those applicants who do not pass the initial screening will not be required to complete this step.**

To the Medical Examiner:

This individual has applied for a position with the British Columbia Forest Service as a fire suppression crew member. During the summer months he/she will be required to perform very physically demanding tasks under mentally and physically stressful conditions. Crew members are required to have physical strength, stamina and coordination to perform a variety of tasks. Working conditions require crew member to:

- work in hot and smoky conditions with a variety of hand tools and equipment;
- exert maximum or near maximum physical effort for prolonged periods of time; and,
- work in steep and rugged terrain, sometimes at high altitudes.

In addition, crew members will are also required to pass and maintain a minimum operational fitness standard. The B C Forest Service Pre-Employment Test standard involves a:

- **Pack Test –** carry a load of 45 lbs. a distance of 4.83km in under 45 minutes at a walking pace, rest 15 minutes, then perform:
- **Pump-Hose test** (job specific) – completed in 4 minutes and 10 seconds (pump and hose carry and hose drag)

Further information about this fitness test can be obtained in the **Fit for Duty** sheet available from Protection Headquarters at (250) 387-5965.

Crew members should be free of any medical condition that might result in incapacitation on the job or which requires frequent medical supervision. Considering the physical demands of a fire suppression work, it is requested that particular attention be paid to the cardiopulmonary and musculoskeletal examinations done on each applicant.

NOTE TO PHYSICIANS: Please retain the main medical report for your records - only the bottom, cut off portion (Certification Document) must be signed and returned to the individual being examined. He/she must bring this signed document to participate in the Bonafide fitness test.

Please cut off the completed **certification document**, and return it to the applicant. **No confidential medical information is required on the applicant's copy of the certification document.**

If you have any questions concerning the applicant's medical fitness for employment, please feel free to contact the Government Employee Health Services physician in Vancouver at (604) 660-0697.

Medical Examination Report
Fire Suppression Crew Member

Date	
Surname Given Name Please write applicant name in tear-off portion below	Date of Birth	Male ❑ Female ❑

Review of Systems (To be completed by Physician)

Has the applicant ever had or been treated for:

Head Injury with LOC	Yes ❑	No ❑	Heart Disease	Yes ❑	No ❑
Dizziness	Yes ❑	No ❑	Diabetes	Yes ❑	No ❑
Migraine Headaches	Yes ❑	No ❑	Gastrointestinal Problems	Yes ❑	No ❑
Loss of Hearing	Yes ❑	No ❑	Musculoskeletal Problems	Yes ❑	No ❑
Allergies	Yes ❑	No ❑	Alcohol/Substance Abuse	Yes ❑	No ❑
Pulmonary Disorders /Asthma	Yes ❑	No ❑	Other Significant Problems	Yes ❑	No ❑

Elaborate on positive responses:

Physical Examination

Height	Weight	Pulse: _________/min BP: /

			Elaborate
Vision: Distant	RT 20/______	LT 20/______	
Corrects to:	RT 20/______	LT 20/______	
Near:	Normal ❑	Abnormal ❑	
Color Vision:	Normal ❑	Abnormal ❑	
Hearing: (Conversational)	Normal ❑	Abnormal ❑	
Cardiovascular	Normal ❑	Abnormal ❑	
Pulmonary	Normal ❑	Abnormal ❑	
Abdomen/Hernias	Normal ❑	Abnormal ❑	
Neurological/Emotional	Normal ❑	Abnormal ❑	
Musculoskeletal ROM	Normal ❑	Abnormal ❑	
Strength	Normal ❑	Abnormal ❑	

Please cut off and return the Certification Document below to applicant. Retain the above portion for your records.

- -

Certification Document (please print)

Name of Applicant: ____

Tests-Investigations as Clinically

No Medical Contradiction to Employment ❑ **(Fit-Unrestricted)**

Employment with Restrictions Recommended ❑ **(Fit-Restricted)**

Not Recommended For Employment ❑ **(Unfit)**

Remarks:

Completed by: (Physician name, address, phone or stamp)

Physician Signature: ______________________________

Date: ______________________________

New Applicant – present this Certification Document at your fitness test