WTST Program health check requirements:

Candidates must have:

- high level of physical fitness and good health
- ability to work at height and in confined spaces

What comprises the medical examination?

The examination covers areas such as:

- ✓ Vertigo or Dizziness
- ✓ Does the candidate have a fear of heights?
- ✓ Does the candidate have a fear of confined spaces?
- ✓ Giddiness or any nervous diseases
- ✓ Use of prescription medication
- ✓ Addictions (urine) test
- ✓ Visual and hearing tests
- ✓ Any restriction of physical movement
- ✓ Stress ECG or EKG of the cardiovascular system – if accepted (Post Requirement)

After a thorough examination the medical practitioner makes recommendations as to whether or not the candidate is suitable for working at heights, in confined spaces and under stressful conditions. Whether or not a staff member is deployed to work under those conditions or not is at the discretion of the employer.

Medical examination:

1. Checks for medical records:
   1.1. History of vertigo / fear of heights or confined spaces
   1.2. Giddiness or nervous diseases
   1.3. Examination of the cardiovascular system

2. Records:
   2.1. permanent medication
   2.2. exclusion of addictions

3. Undertakes:
   3.1. urine test
   3.2. check of visual and hearing faculties
   3.3. stress ECG or EKG – if accepted (Post Requirement)

4. Particular attention is paid to the examination of:
   4.1. Equilibrium or balance
   4.2. Any restriction of physical movement

MEDICAL QUESTIONNAIRE AND REPORT FORM

SECTION A: To be completed by applicant
SECTION B: To be completed by medical practitioner

SECTION A - APPLICANTS DECLARATION

Applicants name:	
I.D. Number:	Date of Birth:
Address:	
Telephone no:	
Current rope access level	Company:
Name, address and telephone no. of own doctor:	

Does any blood relative suffer from, or has ever suffered from, any of the following conditions?:

	YES	NO	If replying "yes", please give brief details
Heart disease			
High blood pressure			
Diabetes			
Asthma			
Mental illness			
Tuberculosis			
Epilepsy			
Any hereditary disease			

Annex A1

Have you ever suffered from any of the following conditions?

	YES	NO
1. Asthma / Hay fever		
2. Eczema		
3. Tuberculosis		
4. Persistent cough		
5. Rheumatic fever		
6. High blood pressure		
7. Severe or persistent headaches		
8. Dizziness or fainting spells		
9. Convulsions / fits		
10. Mental illness		
11. Numbness in arms or legs		
12. Peptic ulcer		
13. Liver or gall bladder disorders		
14. Kidney disease		
15. Painful or difficult urination		
16. Blood in urine		
17. Urethral discharge		
18. back pains		

	YES	NO
19. Joint pins		
20. Eye problems		
21. Blurred or double vision		
22. Ear problems		
23. Difficulty in hearing		
24. Ringing in the ears		
25. Skin problems		
26. Excessive weight loss		
27. Cancer		
28. Diabetes		
29. Malaria or Bilharzia		
30. Fear of heights		
31. Fear of enclosed spaces		
32. Trauma (e.g. accident, snakebite)		
33. Treated for drug / alcohol abuse		
34. Surgical operations		
35. Other hospital admissions		
36. Other illnesses not listed above		

If you answered "yes" to any of the above questions, please give full details below:

……..

……

Annex A1
(continued)

Have you ever been exposed to, or worked with?:

	YES	NO
Gases, fumes or particulate dust		
Loud noise in the workplace		
Asbestos or asbestos mining		
Welding fumes for lengthy periods		

If you answered "yes" to any of the above questions, please give full details below:

……..

……...

Have you ever received compensation for an illness or injury at work? YES / NO……
If you answered "yes" to the above questions, please give full details below:

……..

……...

Have you ever been refused for life insurance? YES / NO? …….
If you answered "yes" to the above questions, please give full details below:

……..

……..

Have you ever been denied a work position on health grounds? YES / NO? ……..
If you answered "yes" to the above questions, please give full details below:

……..

……...

Annex A1
(continued)

Are you allergic to any medication? If answer is "yes, please specify:

……..

Do you have any other allergies (e.g. bee stings)? If answer is "yes", please specify:

……..

Are you taking any medication at present? If answer is "yes", please specify:

……..

Are you presently receiving any treatment from a doctor, hospital or clinic?
If answer is "yes", please specify:

……..

Are you a smoker? If answer is "yes", please state what you smoke, and how many per

day:

……..

Do you consume alcoholic liquor? If answer is "yes". Please state type of liquor and quantity consumed per week:

……..

Do you use any other substances? If answer is "yes", please specify:

……..

I DECLARE THAT THIS PERSONAL STATEMENT AND THE PARTICULARS THEREIN ARE, TO THE BEST OF MY KNOWLEDGE, TRUE AND COMPLETE, AND THAT NO INFORMATION HAS BEEN WITHHELD WICH MAY MATERIALLY AFFECT MY APPLICATION FOR CERTIFICATION.

Signed at…….

Date …….

Applicant's signature ……

Witness ……..

Annex A1
(continued)

SECTION B - MEIDICAL EXAMINATION

Height:	Weight:	Chest (Insp.)	Chest (Exp.)

General appearance of the applicant:

……

Are there any:
Operation scars or skin lesions

……

Signs of hyperlipidaemia

……

Enlarged thyroid or lymphatic glands / tumour

……

Signs of ear disease

……

Abnormalities of oral cavity, including dental

……

Deformities of physical abnormalities

……

Signs of spinal or joint disease

……

Any hernia or varicose veins

……

Any other comments:

……..……

……..

CARDIOVASCULAR SYSTEM

Blood pressure:

Systolic ……..mm.Hg

Diastolic …… mm.Hg.

State of peripheral pulses: rate

……

Are all pulses palpable? YES / NO

……
Any abnormalities?:

……

RESPIRATORY SYSTEM:

Any indication of disease?:

……

Peak flow: Actual ……..
% of predicted …….

GASTRO-INTESTINAL SYSTEM

Any abnormalities?:

……..

CENTRAL VERVOUS SYSTEM

Are the sight (including refractive errors), hearing, speech and gait normal?

……

Visual acuity:
Uncorrected L …… R ……
Corrected L …… R ……
Colour perception: ……..

Urine dipstick (specify type) : ……...
Blood: ……....
Protein: ……....
Glucose: ……....

Any sign or history of mental disorder? ……..

Practitioner's comments on applicant's suitability for work at height and confined:

……...

……...

……...

Initials and surname of examining doctor:	
Telephone no.:	Fax no.:
Qualifications:	Year qualified:
SAMDC no.:	PR no.:
Signature:	Time and date of examination:

IT IS RECOMMENDED THE APPLICANT RETAIN A DUPLICATE COPY OF THIS DOCUMENT