Annex B (informative)
Diver's medical assessment forms

Note: *This Annex is not a mandatory part of this Standard.*

OCCUPATIONAL DIVER'S MEDICAL FITNESS EXAMINATION
CONFIDENTIAL

CANADIAN STANDARDS ASSOCIATION

A diver must not participate in any diving operation if he/she is physically or emotionally fatigued or has used drugs or alcohol that could impair his/her diving abilities.

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DIVER INFORMATION

Last name (please print)	Examination date Month | Day | Year	
First name	Gender ☐ Male ☐ Female	Social insurance number
Home address	Birthdate Month | Day | Year	
City	Province	Postal code
Phone/Cellular/Pager/Fax (specify)		
Mailing address (if different from above)		

Family physician		
Address	City	
Province	Postal code	Phone/Fax (specify)

Employer		
Address	City	
Province	Postal code	Phone/Fax (specify)
Location of diving operation(s)		

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(Continued)

Figure B.1
Occupational diver's medical fitness examination form
(See Clauses A.2.5.1, A.2.6.1, and A.2.7.1.)

OCCUPATIONAL HISTORY

A. DIVING

How long have you been diving (including recreational diving)?

How long have you been employed as an occupational diver? Where?

Date of last occupational diver's medical examination: Performed by Dr. At (city)

Date of last long-bone x-rays:

Have you ever been rejected for diving due to medical reasons? ☐ No ☐ Yes
If yes, give details:

Details on current occupational diving work

Type of diving:
☐ decompression ☐ bounce/yo-yo ☐ contaminated ☐ saturation

Type of diving equipment used:
☐ scuba ☐ surface supply ☐ hookah ☐ rebreather

Type of breathing medium:
☐ air ☐ enriched air/nitrox
☐ mixed gases other than nitrox (specify gases and mixture) _____

Purpose of diving:
☐ scientific ☐ inspection ☐ fish farms ☐ seafood harvesting
☐ police/fire ☐ salvage ☐ construction ☐ other (specify) _____

In the past 5 years, state: (specify metres or feet)

deepest occupational dive	depth _____	bottom time _____	year _____
deepest recreational dive	depth _____	bottom time _____	year _____
longest occupational dive	depth _____	bottom time _____	year _____
longest recreational dive	depth _____	bottom time _____	year _____

Since your last diving medical state:

	Occupational	Recreational
average number of dives per day	_____	_____
average number of dives per week	_____	_____
average depth of dives	_____	_____
average bottom time of dives	_____	_____

B. EMPLOYMENT **OTHER THAN** DIVING

Previous jobs/work experience

Other current jobs (if only diving part-time or seasonally)

Have you had any work-related health problems from current or previous non-diving employment? ☐ No ☐ Yes
If yes, give details:

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(Continued)

Figure B.1 (Continued)

DIVING MEDICAL HISTORY

Have you ever had any of the following disorders during or after diving (occupationally or recreationally)?			
	NO	YES	If "Yes", give details (e.g., date; whether during dive course, recreational or occupational dive; circumstances; treatment; ongoing problems)
• Severe pain in ears or face			
• Rupture of eardrum			
• Lung squeeze			
• Ruptured lung (burst lung)			
• Pneumothorax, pneumomediastinum, subcutaneous emphysema			
• Air embolism			
• Decompression sickness (bends)			
• Bone necrosis/dysbaric osteonecrosis			
• Symptoms such as visual disturbances, ringing in the ears, nausea, vomiting, giddiness, dizziness, irritability, disorientation, twitching, staggering			
• Any other diving injuries/illnesses			

Have you ever filed a WCB claim while employed as a diver? ☐ No ☐ Yes

If yes, was it directly related to your underwater diving activities? ☐ No ☐ Yes

Where did the incident occur? (Specify) _____

FAMILY MEDICAL HISTORY

Is there a history of any of the following in members of your family?			
	NO	YES	If "Yes", give details
• Allergies			
• Asthma			
• Pneumothorax			
• Heart/circulation problems (e.g., hypertrophic cardiomyopathy, sudden cardiac death)			
• High cholesterol (hyperlipidemia)			
• Metabolic problems (e.g., diabetes, thyroid)			
• Other			

Number

(Continued)

Figure B.1 (Continued)

MEDICAL HISTORY

Do you now have, or have you ever suffered from, any of the following?			
	NO	YES	If "Yes", give details, including date(s) (month and year)
• Dental bridgework/plates			
• Facial pain			
• Allergies			
• Hayfever/allergic rhinitis			
• Sinus trouble			
• Nasal obstruction			
• Frequent or severe nosebleeds			
• Difficulty clearing ears when flying or diving			
• Ruptured eardrum			
• Ear infections			
• Hearing problems or hearing loss			
• Ringing in the ears			
• Dizziness			
• Persistent/chronic cough			
• Shortness of breath or trouble breathing			
• Wheezing, asthma			
• Wheezing on breathing cold air/exercising			
• Lung problems requiring inhalers/puffers			
• Bronchitis, pneumonia, or pleurisy			
• Tuberculosis			
• Pneumothorax/collapsed lung			
• Heart trouble or chest pain			
• Irregular/pounding heartbeat			
• High or low blood pressure			
• Blood vessel or circulation problems (including hands and feet)			
• Anemia, blood disorder, bleeding problems			
• Sea or other motion sickness			
• Frequent heartburn, indigestion			
• Peptic (gastric or duodenal) ulcer			
• Hiatus hernia			
• Frequent diarrhea			
• Blood/mucus in stool			
• Inflammatory bowel disease			
• Jaundice or hepatitis			

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(Continued)

Figure B.1 (Continued)

MEDICAL HISTORY *(Continued)*

Do you now have, or have you ever suffered from, any of the following?

	NO	YES	If "Yes", give details, including date(s) (month and year)
• Thyroid or glandular trouble			
• Diabetes			
• Kidney disease (including kidney stones)			
• Broken bones/dislocated joints			
• Rheumatism, arthritis, gout			
• Back injury or disease			
• Hernia (inguinal or umbilical)			
• Severe or frequent headaches			
• Migraines			
• Head injury or concussion			
• Fainting spells, blackouts			
• Convulsions, fits, seizures, or epilepsy			
• Muscle weakness, numbness/tingling			
• Neurological disease			
• Eye disease/injury/surgery or visual problems			
• Colour blindness			
• Skin trouble			
• Insomnia, nightmares, or sleepwalking			
• Nervous breakdown			
• Depression, mania, bipolar disorder			
• Marked anxiety or panic attacks			
• Claustrophobia			
• Fear of open spaces or heights			
• Alcohol or street drug problems			
• Heat or cold-related illness			
• Altitude illness			
• Other serious injury, illness or disease			
HAVE YOU EVER:			
• been hospitalized?			
• had any surgery?			
• been refused or left employment for medical reasons?			

ARE YOU:

• Currently seeing a doctor for any problems? ☐ No ☐ Yes

If yes, give details _____

• Pregnant (or likely to be)? ☐ No ☐ Yes

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(Continued)

Figure B.1 (Continued)

PERSONAL HISTORY

List physically active recreational pursuits (other than diving):

Do you now (or did you in the past year):	NO	YES	If "Yes", give details, including what, when, how much, how often (daily, weekly, or monthly), and whether or not used before or between dives
• Smoke?	☐ never ☐ quit (when) _____		
• Drink alcohol?			
• Take medicines prescribed by a doctor?			
• Take medicines bought without a prescription (over the counter)?			
• Use recreational/street drugs?			

DIVER'S DECLARATION

1) I declare that the contents of this form are accurate with regard to my history and present condition.

2) I authorize the release and exchange of relevant medical information between my family doctor, any examining doctors, and the provincial OHS authority for the purpose of determining my medical fitness to dive.

3) I authorize the release of this examination and classification of my medical fitness to dive to the provincial OHS authority.

Signature of Diver	Date

COMMENTS (for doctor's use only)

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(Continued)

Figure B.1 (Continued)

PHYSICAL EXAM

Date of Examination
Month | Day | Year

General	Height (m) Weight (kg) Body type Obesity Immunization status

			R	L
Vision	Visual acuity — distant	uncorrected		
		corrected		
	Visual acuity — near	uncorrected		
		corrected		

If corrected, please specify eyewear used when diving
☐ magnifying lens ☐ contact lenses ☐ prescription lens in mask

Eyes	Pupils Fundi

	R	L
Ears	Canals	
	Drums	
	Movement of drums with Valsalva manoeuvre	

Nose	Obstruction Mucous membranes

Mouth	Teeth and oral hygiene Dentures (partial or complete)

CVS	Pulse/Heart rate Blood pressure Heart size Heart sounds Murmurs (description) Bruits Peripheral circulation (hands and feet)

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(Continued)

Figure B.1 (Continued)

PHYSICAL EXAM *(Continued)*

Chest	Inspection Palpation Percussion Auscultation
Abdomen	Palpation Hernial orifices
Skin/Scars	
Musculo-skeletal	Spine Upper limbs, including hands (dexterity) Lower limbs, including feet Range of motion Abnormalities
Neurological	Cranial nerves Sensation Tone and power Romberg Tremor Gait Reflexes (0 = absent; 1+ = diminished; 2+ = normal; 3+ = brisk; 4+ = very brisk) R | L biceps triceps radial knee ankle plantar 
Mental status	Affect Any contraindication to diving? ☐ No ☐ Yes If yes, comments _____

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(Continued)

Figure B.1 (Continued)

RESULTS OF REQUIRED INVESTIGATIONS

Please see "Instructions for Completion of Occupational Diver's Medical Fitness Forms" for the periodicity of these investigations.

Blood work	CBC (hemoglobin, WBC, platelets)

Urinalysis	Blood Glucose Protein

X-rays	Chest Skeletal shoulders hips knees R L

ECG	Resting Exercise

Spirometry	FEV_1 FVC FEV_1/FVC FEF25–75%

Audiogram	(Hz)	250	500	1000	2000	3000	4000	6000	8000
	R								
	L								

Other (Investigations/ consultations as clinically indicated)	

PHYSICIAN'S DECLARATION AND CLASSIFICATION

Based on the history, physical, and investigations, and in accordance with the WCB Guidance Notes on Occupational Diver's Medical Fitness Examinations, I have informed the diver of his/her medical fitness to dive as:

Classification

☐ Fit ☐ Unfit ☐ Fit with restrictions (specify restrictions)

Date of examination Month / Day / Year	Date of medical certification Month / Day / Year

Expiry date of medical fitness certificate (must be renewed at least every 2 years up to age 39 and annually from age 40 onwards, or MORE FREQUENTLY IF CLINICALLY INDICATED*)

☐ 2 years from date of examination ☐ 1 year from date of examination ☐ Other*— Specify expiry date_____ (Month/Day/Year)

Physician's signature	Physician's name (please print clearly)	
Mailing address		
City	Province	Postal code
Telephone number	Fax number	

Number

Figure B.1 (Concluded)

OCCUPATIONAL DIVER'S CERTIFICATE OF MEDICAL FITNESS

This certificate of medical fitness is granted as a result of having passed a comprehensive occupational diver's medical fitness examination conducted by a physician knowledgeable and competent in diving medicine.

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DIVER INFORMATION

Diver's last name (please print)	First name(s)	Social insurance number	Date of birth Month / Day / Year
Mailing address	City		Postal code
Home telephone number	Business telephone number		

OCCUPATIONAL DIVER'S MEDICAL FITNESS EXAMINATION RESULTS

Classification

☐ Fit ☐ Unfit ☐ Fit with restrictions (specify restrictions)

Date of examination Month / Day / Year	Date of medical certification Month / Day / Year

Expiry date of medical fitness certificate (must be renewed at least every 2 years up to age 39 and annually from age 40 onwards, or MORE FREQUENTLY IF CLINICALLY INDICATED*)

☐ 2 years from date of examination ☐ 1 year from date of examination ☐ Other*— Specify expiry date _____ (Month/Day/Year)

Physician's signature	Mailing address		
	City	Province	Postal code
Physician's name (please print clearly)	Telephone number	Fax number	

Figure B.2
Occupational diver's certificate of medical fitness
(See Clauses A.2.5.2, A.2.6.2, and A.2.7.2.)