 Survival Systems Survival Systems Training	Issue #: 001	Revision #: 005	Prepared by: PAD
	Document Code: 4216	Issue Date: 08/99	Revision Date: 11/06
	Reference FITNESS CERTIFICATION FOR SURVIVAL SYSTEMS TRAINING TRAINEES		Approved by:

NAME: _____ **PHONE:** _____

ADDRESS: _____ **POSTAL CODE:** _____

This form is to help with the assessment of medical fitness with regard to potential trainees for our survival training courses. **THIS FORM IS FOR FITNESS CERTIFICATION FOR TRAINING ONLY. IT IS NOT VALID FOR OFFSHORE WORK IS VALID FOR THREE MONTHS ONLY FROM DATE OF COMPLETION**

This applicant will undergo strenuous situations both physically and mentally.

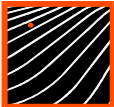
The training can take place in confined, smoke, and fire-filled environments. It can include use of a self contained breathing apparatus, climbing ladders, being inverted in a helicopter simulator under water, and exposure to the elements out at sea during an exercise in which a liferaft is inflated and signal flares fired. **THIS FORM IS GENERIC IN NATURE TO COVER ALL POSSIBLE TRAINING SCENARIOS. IF THERE IS A SPECIFIC CONCERN, PLEASE CONTACT OUR OFFICE AT (800)788-3888.**

The following list contains some of the major medical factors that Survival Systems Training Limited is interested for the assessment of medical fitness.

EXAMINING PHYSICIAN'S OPTIONS:

Has this person ever had or consulted a doctor for any of the following:

- | | <u>Yes</u> | <u>No</u> |
|---|--------------------------|--------------------------|
| 1. Brain or nervous system such as epilepsy, fainting spells, nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Respiratory system such as bronchitis, pleurisy, asthma, hay fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Heart or blood vessels such as a heart murmur, coronary, angina, Increased blood pressure, rheumatic fever, or stroke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Bones or joints such a rheumatism, arthritis, gout, slipped disc, or other back problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Endocrine problems such as diabetes allergies, thyroid problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is this person currently taking prescription medication that would affect their ability to partake in this training? | <input type="checkbox"/> | <input type="checkbox"/> |

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Yes No

7. Is this person fit for survival training courses?

8. If not, is he/she fit for these courses with limitations?
 Specify limitations: _____

TO BE COMPLETED BY PHYSICIAN. An official Medical Office Stamp MUST be included with Physician's Signature

DATE: _____ TELEPHONE: _____

PHYSICIAN'S NAME (PRINT): _____

PHYSICIAN'S SIGNATURE _____

PLEASE PROVIDE PHYSICIAN'S ADDRESS VIA MEDICAL OFFICE STAMP HERE :
↙

CONSENT FOR RELEASE OF INFORMATION

I, _____ (name), OF _____ (address)
 AUTHORIZE DR. _____ (name of examining physician) TO
 COMMUNICATE THE ABOVE INFORMATION REGARDING MY FITNESS TO
 SURVIVAL SYSTEMS TRAINING LIMITED.

Signed: _____ Date: _____ Place: _____

If there are any other questions with regard to this fitness certification, please contact Survival Systems Training Limited at (800) 788-3888.