NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____ **POSTAL CODE:** _____

COURSE NAME AND DATES: _____

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 *and 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:	Yes	No
1. Brain or nervous system: such as epilepsy, fainting spells, nervous disorder?	☐	☐
2. Respiratory system: such as bronchitis, pleurisy, asthma, hay fever?	☐	☐
3. Heart or blood vessels: such as a heart murmur, coronary, angina, increased blood pressure, rheumatic fever, or stroke?	☐	☐
4. Bones or joints: such rheumatism, arthritis, gout, slipped disc, or other back issues?	☐	☐
5. Endocrine problems such as diabetes allergies, thyroid problems?	☐	☐
5. Is this person currently taking prescription medication that would affect their ability to partake in this training?	☐	☐
7. Has this person had major surgery in the last 5 years?	☐	☐
8. Is this person fit for survival training courses?	☐	☐
9. If not, is he/she fit for these courses with limitations?	☐	☐

Specify limitations: _____

_____

_____

Comments: _____

_____

_____

_____

_____

TO BE COMPLETED BY PHYSICIAN.

I, DR. _____, HAVE EXAMINED _____
(Examining Physician) (Patient Name)
TODAY AND FIND THEM FIT TO ATTEND SURVIVAL TRAINING COURSES.

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.