DOCTOR

FIT HEAVY ☐ FIT LIGHT ☐ FIT NO WORK ☐

SECTION G: MEDICAL PRACTITIONER DETAILS

Name:..... Signature:..... Date:.....

BP ☐

STAMP MUST INCLUDE:

Contact Number

Emails Address

Name Of Medical Practitioner

Address

For Official Use Only

Medical Bureau Remarks

Chairperson ***Member*** ***Member*** ***Member***

Date of Medical Bureau Meeting:

Certificate valid until:

Date of Issue:

Issuing Officer:

SECTION D: PHYSICAL EXAMINATION

1. Vital Signs

BP ☐ mm Hg Height ☐ cm

☐ mm Hg Weight ☐ kg

Pulse.....

Rhythm.....

2. General Exam

☐ Normal ☐ Abnormal

Specify (if abnormal):.....

.....

.....

3. Systems

Respiratory	☐	Normal	☐	Abnormal
CVS	☐	Normal	☐	Abnormal
Musculoskeletal	☐	Normal	☐	Abnormal
CNS	☐	Normal	☐	Abnormal
Skin	☐	Normal	☐	Abnormal

Summary of abnormal findings or disability if any:

SECTION E: RESULTS OF INVESTIGATIONS

Chest X-ray comment by medical officer: ☐ Normal ☐ Abnormal

Please describe any abnormalities:

Spirometry Results: FEV_1 ☐ FEV_1 , /FVC% ☐

Date: FVC ☐

Conclusion: Normal ☐ Restrictive ☐ Obstructive ☐ Mixed ☐

SECTION F: RECOMMENDATIONS BY MEDICAL PRACTITIONER *(tick where applicable)*

Suitable for work in a dusty occupation

☐ **Yes** ☐ **No**

☐ Review of work place controls required, (specify) :.....

.....

Is there any additional medical information you would like to bring to the attention of the Bereau

☐ **Yes** ☐ **No**

If yes please specify:.....

In your opinion do you consider that the examinee is: ***(Tick where Applicable)***

☐ **Free from TB** ☐ **TB Suspect** ☐ Confirmed TB

Worker referred for further tests **Yes** ☐ **No** ☐

Specify additional test requested and attach results if available

☐ Sputum for AAFB'S

☐ ECG

☐ ECHO

☐ CT SCAN

☐ OTHER Specify:.....

2. Demographic Details

Name: | Contact Number:

3. Employment Details:

Current Job Title: | Employment Commencement Date:

Job Station:

☐ Underground ☐ Plant

☐ Surface ☐ Others Specify

Any previous work history in a Dusty Occupation?

No ☐ Yes ☐

If Yes provide Details Below

Occupation	Years' Worked	Exposure

SECTION C: PERSONAL HEALTH QUESTIONNAIRE

1. Are you suffering from any of the following symptoms:

☐ Cough (longer than 3 weeks) ☐ Coughing up blood

☐ Night sweats ☐ Weight loss (unintentional)

☐ Shortness of breath ☐ Loss of appetite

☐ Chest pains ☐ Chest tightness

2. Have you ever been diagnosed of any of the following Medical Conditions:

☐ TB ☐ Asthma

☐ COPD ☐ Diabetes

☐ Pneumonia ☐ Epilepsy

☐ Hypertention ☐ Heart disease

☐ Chest injuries ☐ Hernia (specify)

3. Smoking History : Do you smoke?

☐ **Yes**

How many cigarettes per day .....

For how long (Specify in years).....

.....

.....

☐ **No**

Past Smoker

☐ **Yes** ☐ **No**

For how long (Specify in years).....

.....

.....

I certify that I have answered these questions truthfully and to the best of my knowledge.

Patient Signature **Date**

nssa
A Lifelong promise

APPLICATION FOR FITNESS CERTIFICATE

(Pneumoconiosis Statutory Medical Examinations: Pneumoconiosis Act Chapter 15:08)

Purpose of the Examination:

- ☐ Pre-Placement
- ☐ Periodical
- ☐ Exit (Employment Termination)
- ☐ Post Employment Follow Up

SECTION A: EMPLOYER/OCCUPIER *(to be completed by employer)*

1. Details of person conducting the business or undertaking

Company/Organisation name:

Site Address:	
Site Telephone:	Province:
Contact Person:	Designation:
Email Address:	Contact Number:

2. Details of work environment

Industry Classification:

- ☐ Mining ***(Specify Mineral)***.....
- ☐ Quarrying,
- ☐ Manufacturing,
- ☐ Construction,
- ☐ Agriculture,
- ☐ Other .....

Which Mineral dust exposure is causing the health Risk?

- ☐ Silica
- ☐ Coal
- ☐ Asbestos
- ☐ Other .....

3. Details of control measures being implemented:

- ☐ Use of wet method
- ☐ Containment and ventilation
- ☐ Exposure monitoring (workplace dust level surveys)
- ☐ PPE (Specify):
- ☐ Other:

SECTION B: WORKER *(to be completed by worker)*

1. Demographic Details

Surname: _____ First Name: _____

Date of birth: ☐☐☐☐☐☐☐☐ Sex: Male ☐ Female ☐

National ID number:	Medical Bereau Number:
Contact Number:	