State Emergency Service (VIC)

Volunteer Fitness for Duty

Volunteer Fitness for Duty Questionnaire

Unit Details:

Unit Controller: ..... Controller's Mobile Phone: .....

Unit Controller's Email: .....

SES Region: ..... SES Unit: .....

Regional Manager's Name: ..... Manager's Phone: .....

Regional Manager's Email: .....

Volunteer Details:

Membership status: ◯ New Member ◯ Existing Member If existing, years of service: .....

SES ID Number: ..... Proposed Role: ◯ Operational ◯ Non-Operational

Surname: ..... First Name: .....

Home Address: .....

Suburb: ..... Postcode: .....

Date of Birth: ..... *(dd/mm/yyyy)* Male ◯ Female ◯ Other ◯

Height: ..... (cm) Weight: ..... (kg)

Home Phone: ..... Mobile: .....

Email: .....

Volunteer Information:

- If this form is not complete, sections are left blank or incomplete, or the names of your treating or previous doctor(s) not provided this will result in:
  - The form being returned to the volunteer, or
  - additional time being taken to assess your fitness for duty.
- Please complete your details on this cover page, the following health questionnaire (pages 3-8) and sign the volunteer declaration on page 8 You must answer every question.
- Please use blue or black pen ONLY.
- **Please pay particular attention to Table 1 on page 2 of this document**. If you have ever suffered from any of the conditions listed in this table, please provide the additional information to Injurynet when you send through your completed questionnaire
- **Once completed, fax or email all pages of this form to Injurynet on (03) 9012 3521 or** mas@injurynet.com.au
- If it is not possible for you to get any required information back to Injurynet, please call Injurynet on (03) 9500 9968 to discuss alternative arrangements.
- Additional information, if not provided at the same time as this medical form, can be faxed to Injurynet on (03) 9012 3521 or emailed to mas@injurynet.com.au Please ensure any documents clearly state your name and what the document relates to so that they can be easily identified upon receipt.

Table 1 - IMPORTANT NOTE TO ALL VOLUNTEERS

If you suffer, or have suffered from, any of the following condition/s then please provide the following information to Injurynet when emailing or faxing your completed questionnaire.

Condition	Required Information
Diabetes	• Most recent Hba1c pathology lab result • Information or letter from treating doctor commenting on: o Control of diabetes o Current treatment o Presence of hypos o Presence of complications e.g. heart, feet, eyes, feet o Any impact on function or fitness to drive o If recommended to have a conditional driver's licence according to the Austroads guidelines
High Blood Pressure (hypertension)	• Information or letter from treating doctor showing: o Dates and measurements of the last 3 blood pressure measurements
Sleep Apnoea or other sleep disorder (past or current)	• Information or letter from treating doctor commenting on: o Diagnosis o Any consequences of condition e.g. accidents, other medical conditions o Current treatment o Monitoring of response to treatment o Presence of any current symptoms o Any impact on function or fitness to drive o If recommended to have a conditional driver's licence according to the Austroads guidelines
Heart problem (other than blood pressure) including heart attacks, stenting valve or rhythm problems	• Information or letter from treating doctor commenting on: o Diagnosis o Current treatment o Presence of any current symptoms o Any impact on function or fitness to drive o If recommended to have a conditional driver's licence according to the Austroads guidelines
Stroke including minor or temporary TIAs	
Shortness of breath during normal activities	
Significant hearing loss or have been fitted for hearing aids	
Significant muscle or joint condition (e.g. hip replacement)	
Psychological condition that requires regular review of treatment	
Epilepsy, fits, seizures, blackouts, faints or vertigo	• Information or letter from treating doctor commenting on: o Diagnosis o Approximate date of most recent episode o Current treatment o Any impact on function or fitness to drive o If recommended to have a conditional driver's licence according to the Austroads guidelines
Vision problem that isn't corrected by glasses	• Information or letter from treating doctor or optometrist commenting on: o Diagnosis o Current treatment o Presence of any current symptoms o Any impact on function or fitness to drive o If recommended to have a conditional driver's licence according to the Austroads guidelines
Asthma or other lung condition	• Information or letter from treating doctor commenting on: o Control of asthma/condition o Current treatment o Frequency of exacerbations o Any impact on function

Questionnaire - Volunteer to complete

1) Do you have, or have you had, any condition or disability that may affect the work to be undertaken for the VICSES? ☐ Yes ☐ No

If **YES**, please provide details below:

Nature & Description of Condition	Month & Year of Onset	Current status of condition

2) Please indicate in the box below how these conditions currently impact on you in your day to day activities:

3) Are you currently employed? ☐ Yes ☐ No

If **YES**, please give details about the type of work you perform: _____

4) Have you ever had any other illnesses, injuries, operations or fractures? ☐ Yes ☐ No

If **YES**, please provide the following details:

Nature of Injury / Illness	Month & Year of Onset	Approx Time to Recovery (Write "Not" if not recovered)	Amount of Time Off Work

5) Are you currently taking any medication or have you taken any medication (including over the counter or vitamins) **for more than 2 weeks** within the past two years? ☐ Yes ☐ No

If **YES**, please complete the following details:

Name of Medication	Condition	Approximate duration medication taken	
		From:	To:
		From:	To:
		From:	To:
		From:	To:

6) Do you currently have any work restrictions certified by a doctor? ☐ Yes ☐ No

If **YES**, please specify: _____

7) Have you ever been diagnosed with diabetes? ☐ **Yes - complete this question** ☐ No – proceed to question 8.

A. Is your diabetes well controlled? ☐ Yes ☐ No

If **NO**, please describe: _____

B. Do you take insulin? ☐ Yes ☐ No

C. Have you experienced any hypos in the last 12 months? ☐ Yes ☐ No

If **YES**, please describe: _____

D. Have you had any complications (e.g. kidney, heart or eye issues and/or loss of feeling in hands or feet)? ☐ Yes ☐ No

If **YES**, please describe: _____

Questionnaire continued - Volunteer to complete

E. How often do you see a doctor for check-ups? _____

F. What was your last Hba1c reading? _____ Approx. date of test? _____ (MM/YY)

8) Have you ever had, or been told that you have had asthma? ☐ **Yes - complete this question** ☐ No – proceed to question 9.

A. Is your asthma well controlled? ☐ Yes ☐ No

B. How many puffs of relieving medication (e.g. Ventolin) do you take during an average week? _____

C. Do you use preventative sprays? ☐ Yes ☐ No

D. Have you required oral prednisolone, cortisone or other oral steroids in the last three years? ☐ Yes ☐ No

If **YES** to D, how many times? _____

E. Is your asthma affected by exercise? ☐ Yes ☐ No

F. How many attacks do you have a year on average? _____

G. Have you been hospitalised for asthma in the last two years? ☐ Yes ☐ No

9) Please complete the following table by ticking the appropriate box for every question relating to your tendency to doze in the following situations:

Epworth Sleep Scale	Would never doze off (0)	Slight chance of dozing or sleeping (1)	Moderate chance of dozing or sleeping (2)	High chance of dozing or sleeping (3)
Sitting and reading				
Watching TV				
Sitting inactive in a public place				
Being a passenger in a motor vehicle for an hour or more				
Lying down in the afternoon				
Sitting and talking to someone				
Sitting quietly after lunch (no alcohol)				
Stopped for a few minutes in traffic while driving				
TOTAL				

Do you have or have you ever experienced the following? Please answer all questions by writing **YES** or **NO** in the box. **[DO NOT TICK]**

Item No.	Condition	Yes or No
10	Arthritis, joint pain or swelling?	
11	Numb fingers or hands?	
12	Carpal tunnel syndrome?	
13	Tennis elbow or golfers elbow?	
14	Tendonitis?	
15	Wrist pain, injury or ganglion?	
16	Repetitive strain (RSI) or overuse injury or pain?	
17	Knee injury, swelling or pain?	
18	Back pain or disc problems?	
19	Sciatica or leg pain?	
20	Neck pain, stiff neck or whiplash?	
21	Shoulder pain, tendonitis or frozen shoulder?	
22	Hip pain?	
23	Treatment on back or neck?	
24	Back or neck x-ray or scan?	
25	Depression?	
26	Fear or phobias e.g. to heights, confined spaces?	
27	Anxiety, nervous illness or breakdown which you have discussed with a doctor or counsellor?	
28	Mental illness such as Schizophrenia or Bipolar Disorder?	
29	Hypertension? (High blood pressure)	
30	Heart attack or angina?	
31	Stroke or temporary stroke attacks?	

Questionnaire continued - Volunteer to complete

Item No.	Condition	Yes or No
32	Epilepsy, fits, blackouts or coordination problems?	
33	Dizzy spells, fainting or attacks of unconsciousness?	
34	Migraines, regular headaches or head injuries?	
35	Sleep disorder or sleep apnoea?	
36	Shortness of breath or persistent cough?	
37	Hernia in the groin or elsewhere?	
38	Hepatitis or liver problems?	
39	Cancer or tumour of any type?	
40	Any skin condition affecting the hands or feet?	
41	Feet or ankle problems or foot pain on standing/walking?	
42	Drug or alcohol problems?	

FOR ALL QUESTIONS CONTAINED IN TABLE ABOVE ANSWERED WITH A "YES", PLEASE COMPLETE THE TABLE BELOW. IF YOU NEED MORE SPACE THAN IS PROVIDED, PLEASE WRITE ON A BLANK PIECE OF WHITE, A4 PAPER AND INCLUDE WITH THE QUESTIONNAIRE. DO NOT WRITE ON THE BACK OF THE PAGE.

Question No. (e.g. 17)	**Month/Year of Onset** (e.g. June 2010)	**Severity and Treatment** (e.g. Severe lower back pain with leg pain. Treated by physio for two months)	**Time to Recovery** (e.g. two months. Write "Not" if not recovered)	**Current Status** (e.g. Occasional ache in lower back)

43) Do you have tinnitus, ringing in the ears, hearing loss or other hearing difficulties? ☐ Yes ☐ No

If **YES**, please provide details:

44) Do you have any deficits in your vision? ☐ Yes ☐ No

If **YES**, please provide details:

Questionnaire continued - Volunteer to complete

Is there any reason/s you would be **unable** to perform the following tasks or activities fully?

Please answer all questions by writing **YES** or **NO** in the box **[DO NOT TICK].**

Item No.	Activity	YES or NO	Item No.	If **YES** to any of the below questions, please provide details explaining the extent of the limitation
45	Standing for 30 minutes			
46	Standing for long periods			
47	Walking up to 30 minutes			
48	Walking long distances			
49	Walking on uneven ground			
50	Walking up and down steep hills			
51	Climbing steps or ladders			
52	Lifting more than 15 kg			
53	Bending			
54	Twisting			
55	Squatting			
56	Kneeling			
57	Sitting			
58	Working above your head			
59	Wearing standard safety equipment shoes, boots, glasses, helmet etc.			
60	Any other limitation not specified			

Do you believe there are **medical limitations** on your ability to perform the following tasks for the SES?

Please answer all questions by writing **YES** or **NO** in the box. **[DO NOT TICK]**

Item No.	TASK	YES or NO	If **YES** to any of the below questions, please provide details explaining the extent of the limitation
61	**Road Crash Rescue**		
a)	Driving truck under lights and siren to respond to an accident.		
b)	Provide lighting to the site of the accident		
c)	Traffic management		
d)	Using the jaws of life cutting implement (19 kg weight)		
e)	Manual starting of generator or water pumps		
62	**Storm**		
a)	Climb onto a roof in a safety harness to tarp the roof in inclement weather		
b)	Use the chainsaw to cut up trees that have the potential to damage people or property		
c)	Hand sawing		
63	**Supporting Police**		
a)	At crime scenes/suicides - Isolating a crime scene		
b)	Searching for evidence		
64	**Search and Rescue**		
a)	In rugged terrain for up to 12 hours		
b)	Carrying casualty or body out from remote locations		
c)	Working in smoky environment		
d)	Vertical rescues e.g. for casualties fallen over the edge of a cliff		
65	**Communications**		
a)	Radio communications to allocate tasks		
66	**Administration**		
a)	Data input up to 3 hours per week		
67	**Situation Reporting**		
a)	Driving to various tasks to ascertain the requirement for resources in storms, up to 12 hours driving.		

Optional General Practitioner Comments

Please ask your G.P. to complete only if you believe this will assist in explaining your condition(s).

To the G.P.

Your patient is either applying to become a member for the State Emergency Service (SES) or is an existing member for whom a health issue has been identified.

The role of an operational member of the SES includes the following:

- Lifting and bending
- Climbing on ladders while carrying equipment
- Lifting, bending, pulling
- Working in challenging environments, including high winds, rain, floods, and uneven surfaces
- Climbing on rooves.

Please provide information on this person's condition, including diagnosis, progress, impact on function, treatment, prognosis, suitability for role…

We may call you to discuss further.

_____ _____

General Practitioner's Stamp/Name General Practitioner's Signature

[_____]_____ _____/_____/_____

Telephone Number Date

Questionnaire continued - Volunteer to complete

68) Please provide details of your **current** doctor or medical clinic:

Name:	
Telephone No:	
Address:	

69) Please provide details of any **other** doctor/s or health practitioner/s you have consulted in the past **five (5)** years:

Name:	
Telephone No:	
Address:	

Name:	
Telephone No:	
Address:	

DECLARATION – Volunteer to complete

The Volunteer FFD Questionnaire Form is a confidential document and access is limited to a "need to know" basis. VICSES will retain this form on your confidential file and reserves the right to refer to the information in the event of an accident, injury, sickness or claim for worker's compensation. The information may also be used for other purposes, if so required by law.

I hereby declare that:

- I have read and understood the conditions on this form.
- I understand that the information I provide will be retained by VICSES and their medical advisors from Injurynet on my confidential medical file and that VICSES reserves the right to refer to the information, in the event of an accident, injury, sickness or claim for workers' compensation or for any other lawful purposes.
- I am aware that a copy of Injurynet's Privacy Statement is available at www.injurynet.com.au/privacy and that this statement provides details about how I can access, update and correct my information and, if I am concerned about how this information has been handled, how I can lodge a privacy complaint including how this will be dealt with.
- I consent to VICSES and its' medical representatives obtaining or exchanging further medical information from my treating doctor/s or other health practitioner/s, if required, for the purposes of this assessment.
- In the event that further information is needed to complete this assessment, I understand that I may be contacted by an Injurynet representative and asked to provide further information and/or I may also be required to attend a medical examination.
- I understand and agree that the assessing doctor may contact the unit controller in order to understand unit-related issues regarding reasonable adjustment. This will not include the doctor disclosing medical information to the unit controller.
- If required to attend a medical examination, I consent to the release of this form to the doctor conducting the assessment.
- My answers relating to my medical and employment history are true and complete to the best of my knowledge.

_____	_____	_____/_____/_____	_____/_____/_____
Full Name of Volunteer (Please Print)	Signature of Volunteer	Date	Date of Birth