FREMANTLE commercial diving

Personal Information

Contact Details

First Name(s):			Last Name:		
Address:					
Telephone:			Date of Birth:	Age:	Sex: ☐ Male / ☐Female
Position Applying For:					
Treating / Family Doctor:				Doctor Contact Details:	

Personal Health

Question			Details
Do you smoke?	☐ Yes	☐ No	If yes, how many per day?____________________
Have you stopped smoking?	☐ Yes	☐ No	If yes, when?_______________________________
Do you drink alcohol?	☐ Yes	☐ No	Average number of days per week?___________ Number of drinks per sitting?_________________
Do you exercise?	☐ Yes	☐ No	If yes, what type?___________________________ Average number of days per week?___________ Length of time each session?________________
Have you any illness or disability at present?	☐ Yes	☐ No	Specify:_____________________________________
Have you been involved in a Motor Vehicle Accident?	☐ Yes	☐ No	Date:_______________________________________

Question		
Are you taking medicines, mixtures or tablets at present? If yes, please specify:	☐ Yes	☐ No
Have you ever had any allergy from, or reacted to any antibiotic, medicines, drugs, insect bites, food or anything else? If yes, please give details:	☐ Yes	☐ No
Are you receiving treatment for any medical conditions? If yes, please give details:	☐ Yes	☐ No

Personal Health History: Tick Yes or No to the following questions.		
Do you have any physical disability?	☐ Yes	☐ No
Is there any defect in the sight of either eye?	☐ Yes	☐ No
Are you colour blind?	☐ Yes	☐ No
Have you any defect in hearing?	☐ Yes	☐ No
Are you affected by vertigo (fear of heights)?	☐ Yes	☐ No
Are you able to work while located at a height?	☐ Yes	☐ No
Do you suffer from claustrophobia (fear of confined spaces)?	☐ Yes	☐ No
Have you had any back/neck trouble of any kind?	☐ Yes	☐ No
Have you had any heart trouble or angina?	☐ Yes	☐ No

Have you had any severe injury or operation?	☐ Yes	☐ No
Have you ever had any bone fractures or dislocations?	☐ Yes	☐ No
Have you ever had any ankle/knee trouble of any kind?	☐ Yes	☐ No
Have you ever had a rupture (hernia)?	☐ Yes	☐ No
Have you ever had wrist/elbow trouble of any kind?	☐ Yes	☐ No
Have you ever had any nervous trouble, epilepsy or fainting?	☐ Yes	☐ No
Have you ever had any fits, seizures or blackouts	☐ Yes	☐ No
Have you suffered from depression or anxiety?	☐ Yes	☐ No
Have you ever had skin trouble (dermatitis)?	☐ Yes	☐ No
Have you ever had repetitive strain injury?	☐ Yes	☐ No
Have you ever had stomach ulcers, gall or kidney disorders	☐ Yes	☐ No
Have you ever had whiplash from an accident?	☐ Yes	☐ No
Do you have any allergies?	☐ Yes	☐ No
Is there any family history of disease like diabetes?	☐ Yes	☐ No
Have you a tendency to bleed or bruise excessively?	☐ Yes	☐ No
Have you ever had Asthma, Tuberculosis or Pleurisy?	☐ Yes	☐ No
Have you ever had hepatitis, jaundice or liver trouble?	☐ Yes	☐ No
Have you ever had Rheumatics or Arthritis of any form?	☐ Yes	☐ No
Have you ever had Goitre or Thyroid troubles?	☐ Yes	☐ No
Have you ever had high blood pressure?	☐ Yes	☐ No
Have you ever had kidney or bladder disease?	☐ Yes	☐ No
Have you ever had cancer or tumour of any kind?	☐ Yes	☐ No
Have you ever had ear discharge, antrum or sinus trouble?	☐ Yes	☐ No
Have you ever had persistent or frequent headaches/migraines?	☐ Yes	☐ No

Personal Health History Continued: Tick Yes or No to the following questions.		
Have you ever had any illness or suffered any breakdown, met with any injury or wound or undergone any surgical operation not already stated above? If yes, give details:	☐ Yes	☐ No
Have you ever had a workers' compensation claim? If yes, give details:	☐ Yes	☐ No
Have you been involved in a Motor Vehicle Accident? If yes, give details:	☐ Yes	☐ No

Manual Handling		
Have you ever been treated for an injury as a result of attempting to lift, lower, push, pull, carry or otherwise move, hold or restrain any object?	☐ Yes	☐ No
Do you suffer from any medical or health related condition that may affect your ability to lift, lower, push, pull, carry or otherwise move, hold or restrain any object?	☐ Yes	☐ No
Do you suffer from any medical or health related condition that may be affected by physical or strenuous work? (E.g. repetitive strain injuries related to manual handling, lower back pain, hernia or haemorrhoids, a heart condition, high blood pressure, a respiratory condition such as asthma etc.)	☐ Yes	☐ No

Have you had or do you currently have any of the following:

Condition	Yes	No	Condition	Yes	No
Swollen or painful joints	☐ Yes	☐ No	Neck injury	☐ Yes	☐ No
RSI	☐ Yes	☐ No	Back injury	☐ Yes	☐ No
Knee injury	☐ Yes	☐ No	Other joint injury	☐ Yes	☐ No
Fractures	☐ Yes	☐ No	Shoulder injury	☐ Yes	☐ No
Ankle injury	☐ Yes	☐ No	Other:	☐ Yes	☐ No

If you have answered 'yes' to any of the questions in this section, please provide details (e.g. dates, what happened, nature of injury/medical condition, treatment details, length of time off work, etc.)

Driving		
Are you currently being treated by a doctor for any illness or injury?	☐ Yes	☐ No
Are you receiving any medical treatment or taking any medication? (either prescribed or otherwise)	☐ Yes	☐ No

Have you ever had or been told by a doctor that you had any of the following?

Condition			Condition		
High blood pressure	☐ Yes	☐ No	Blackouts, fainting	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Chest pain, angina	☐ Yes	☐ No	Dizziness, vertigo, problems with balance	☐ Yes	☐ No
Any condition requiring heart surgery	☐ Yes	☐ No	Double vision, difficulty seeing	☐ Yes	☐ No
Palpitations/irregular heartbeat	☐ Yes	☐ No	Colour blindness	☐ Yes	☐ No
Abnormal shortness of breath	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
Head injury, spinal injury	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Seizures, fits, convulsions, epilepsy	☐ Yes	☐ No	Neck, back or limb disorders	☐ Yes	☐ No
Hearing loss or deafness or had an ear operation or use a hearing aid				☐ Yes	☐ No

Do you have difficulty hearing people on the telephone (including use of hearing aid if worn)?	☐ Yes	☐ No
Have you ever had or been told by a doctor that you had a psychiatric illness, or nervous disorder?	☐ Yes	☐ No
Have you ever had any other serious injury, illness, operation or been in hospital for any reason?	☐ Yes	☐ No
Have you ever had, or been told by a doctor that you had a sleep disorder, sleep apnoea or narcolepsy?	☐ Yes	☐ No
Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep?	☐ Yes	☐ No

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.
Use the following scale to choose the most appropriate number for each situation:

0 - would never doze off
1 - slight chance of dozing
2 - moderate chance of dozing
3 - high chance of dozing

It is important that you put a number (0 to 3) in each of the 8 boxes below.

Situation	Chance of dozing (0-3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	

Chemical Exposure		
Have you ever been treated for an injury, illness or side effect as the result of being exposed to chemical or toxic substances or using of PPE? (eg gloves)	☐ Yes	☐ No
Do you suffer from any medical or health related condition that may be affected as the result of being exposed to medications, detergents, cleaning solutions, and pesticides? (eg respiratory conditions such as asthma, dermatitis or eczema, allergenic reactions, etc)	☐ Yes	☐ No
Is there any reason that you can't wear safety or protective equipment (ie safety foots, ear muffs or plugs, helmet or safety glasses)?	☐ Yes	☐ No

Have you had or do you suffer from:

Eczema	☐ Yes	☐ No	Allergies	☐ Yes	☐ No
Dermatitis	☐ Yes	☐ No	Loss of consciousness	☐ Yes	☐ No
Other skin problems	☐ Yes	☐ No	Epilepsy or fainting	☐ Yes	☐ No

If you have answered 'yes' to any of the questions in this section please provide details (e.g. dates, what happened, nature of injury/medical condition, treatment details, time off work, etc.)

Diving

Have you ever had:

Decompression illness	☐ Yes	☐ No	Barotrauma	☐ Yes	☐ No
Vertigo / Dizziness	☐ Yes	☐ No	Speech impairment	☐ Yes	☐ No
Frequent or severe ear aches, infections or problems (including middle, inner or outer ear)				☐ Yes	☐ No

Have you ever had, or is it likely that you would have difficulty with the following tasks:

Standing for up to 30 minutes	☐ Yes	☐ No	Sitting for up to 30 minutes	☐ Yes	☐ No
Lifting heavy weights above 15 kg	☐ Yes	☐ No	Working in hot or cold extremes	☐ Yes	☐ No
Climbing ladders	☐ Yes	☐ No	Using hand tools	☐ Yes	☐ No
Operating machinery	☐ Yes	☐ No	Shift work	☐ Yes	☐ No
Wearing PPE	☐ Yes	☐ No	Working in confined spaces	☐ Yes	☐ No
Crouching, bending or kneeling	☐ Yes	☐ No	Repetitive movements of hands or arms	☐ Yes	☐ No

Psychological		
Have you ever received medical treatment for a stress related condition? (eg ulcers, nervous trouble, insomnia, depression, anxiety or panic attacks, nervous breakdown)	☐ Yes	☐ No
Have you ever received counselling for a stress related condition?	☐ Yes	☐ No
Have you or do you suffer from a psychological condition?	☐ Yes	☐ No

If you have answered 'yes' to any of the questions in this section please provide details (e.g. dates, what happened, nature of condition, treatment details, time off work, etc.)

Infectious Diseases: Have you had any of the following diseases?					
Measles	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No
German Measles	☐ Yes	☐ No	Other:	☐ Yes	☐ No

Immunisations: Have you been immunised against?			
COVID-19	☐ 1	☐ 2	☐ Booster
Tuberculosis	☐ Yes	☐ No	Year:
Mantoux	☐ Yes	☐ No	Year:
Hepatitis A	☐ Yes	☐ No	Year:
Hepatitis B	☐ Yes	☐ No	Year:
Rubella	☐ Yes	☐ No	Year:
Other/Further Information:			

Applicants Declaration

Do you have any other health concerns or medical conditions you are aware of that may affect

- Your ability to undertake the work, or that
- This organisation should be made aware of, so that it can fulfil its own duty of care to its employees.

If so, please provide details (e.g. dates, what happened, nature of injury/condition, treatment details, etc.)

Section 79 of the *Western Australian Workers' Compensation and Injury Management Act 1981* gives a dispute resolution body discretion to refuse to award compensation which would otherwise be payable where it is proved that the worker has, at the time of seeking or entering employment in respect of which he claims compensation for an injury, wilfully and falsely represented themselves as not having previously suffered from the injury.

I, ______________________________, hereby declare that the particulars on this form are, to the best of my knowledge, correct and true.

I also understand and am aware that any inaccurate statement made, or information withheld, may result in the termination of my employment/contract.

Print Name:	Signed:	Date:
Applicant:		
Witness:		