APPENDIX G

Health Fitness Certificate

for the purposes of permission to work in Confined Space

Named of Person examined …………………………………………………………………

NRIC/Passport No. ………………………………………………. Date of Birth………………

Name and addressed of Employer:

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

I hereby certify that I have examined the abovenamed person on ………………………………

From the information related to health being declared by the person, my clinical examination and diagnostic tests recorded on medical examination form, I certfy that this worker is

☐ FIT
☐ NOT FIT

for working in confined space.

Doctor's signature: ____________________

Date: ____________________

Name of OHD: ____________________

DOSH RN: ____________________

Name of clinic: ____________________

____

Tel and Fax no: ____________________

APPENDIX H

MEDICAL EXAMINATION CHECKLIST FOR WORKING IN CONFINED SPACE
(TO BE FILLED UP BY OCCUPATIONAL HEALTH DOCTOR)

This is to certify that the below statements are true. I give consent to the OHD for medical examination and to communicate with the management regarding my work capability after discussion with me.

Worker's signature: ______________________ Date: __________

A) Worker

Name: ______________________
Address: ______________________
____
Postcode: __________ District: __________ State: __________
Tel No: ______________________
IC No: ______________________
Age: ______ years Sex: Male ☐ Female ☐

Ethnic: Malay ☐
Chinese ☐
Indian ☐
Others ☐

Marital status:
Single ☐
Married ☐

Nationality: Malaysian citizen ☐
Non citizen (specify) ☐

B) Next of kin to be contacted in case of emergency

Name: ______________________
Relationship: ______________________
Address: ______________________
____
Tel No: ______________________

C) Employer

Name: ______________________
Address: ______________________
____
____
Tel No: __________ Fax No/E-mail: __________

D) Occupational History

1. Job title: ____________________
2. Duration of service: ____________________
3. Any training received for this job? Yes ☐ No ☐
4. Other job (other than this job): ____________________
5. H/O using any PPE Yes ☐ No ☐
   Specify: ____________________
6. H/O allergy or difficulty in using PPE Yes ☐ No ☐
   Specify: ____________________

E) Do you have any history of or suffering from the following conditions?

1. Smoking:
   a) Smoker ☐
   b) Non smoker ☐
   c) Stopped smoking ☐

No of years smoked: ☐ years
No of cigarette/day: ☐

2. Medical condition	Yes	No	Remarks
a) Eye problems (including visual acuity, or night blindness)			
b) Ear problems (including hearing, inner ear disease or recurrent vertigo)			
c) Nose (trouble smelling odours)			
d) Central Nervous System:			
i) Epilepsy, fits or convulsion of any kind			
ii) Stroke with residual abnormality			
iii) Disease affecting co-ordination e.g., Parkinson			
iv) Serious head injury			
v) Severe headache, giddiness or migraine			
e) Cardiovascular System:			
i) Uncontrolled hypertension			
ii) Heart disease (including IHD, Heart failure or Arrythmia			
iii) Congenital heart disease with cardiomegaly, ECG abnormality or inadequate oxygenation			
f) Respiratory System:			
i) Uncontrolled asthma			
ii) COAD			
iii) Acute pulmonary infection (including TB)			

	Yes	No	Remarks
g) Gastrointestinal System:			
i) Peptic ulcer disease			
h) Endocrine System:			
i) Uncontrolled diabetes mellitus			
i) Renal System:			
i) Chronic renal disease e.g., nephritis			
ii) Renal failure			
j) Musculoskeletal System:			
i) Deformity, disability or amputation of the body/limbs			
ii) Chronic or recurrent disease of muscle, bone or joint			
k) Dermatological System:			
i) Acute or chronic inflammatory skin condition			
l) Psychiatric			
i) Mental illness (including depression, psychosis, mania or anxiety)			
ii) Drug and alcohol dependent (current or past)			
iii) Claustrophobia (fear of enclosed spaces)			
m) H/O taking any medications			
i) Cough/cold medication			
ii) Transquilisers			
iii) Hypnotics			
iv) Other drugs (including cytotoxic agents, anti-coagulants or immunodepressants)			
n) Any other health problem or injury			

F) Family history

	Yes	No	Specify (if yes)
1. H/O medical illness:			
2. H/O allergy:			
3. Other illness (specify):			

G) For female only

Currently Pregnant Yes ☐ No ☐

H) Physical examination

1. Anthropometry

a) Weight: ____________ kg
b) Height: ____________ cm
c) BMI: ____________

2. Vital sign:

a) Blood pressure ____________ mmHg   b) Pulse rate ____________ per minute

3. General condition:

a) Eye:

	Right	Left
i) Visual acuity		
ii) Visual field		
iii) Colour vision		
iv) Fundoscopy		

b) Ear:

	Right	Left
i) External ear		
ii) Tympanic membrane		
iii) Air conduction		
iv) Bone conduction		

c) Nose

Right	Left

d) Throat ____________

e) Skin ____________

f) Lymph nodes ____________

4. Target organ:

	Normal	Abnormal	Specify (if abnormal)
a) Central Nervous System			
b) Cardiovascular System			
c) Respiratory System			
d) Gastrointestinal System			
e) Endocrine System			
f) Renal System			
g) Musculoskeletal System			

I) Investigations

	Date	Normal	Abnormal	Remarks
1. FBC				
2.UFEME				
3. Spirometry:				
FVC				
FEV1				
FEV1/FVC				
4. Other (specify)				

On the basis of the applicant's personal declaration, my clinical examination and diagnostic test results recorded on the medical examination form, I declare that this worker is FIT / NOT FIT for working in confined space.

Doctor's signature: ____________________

Name of OHD: ____________________ DOSH RN: ____________

Name of clinic: ____________________ Clinic tel no: ____________

Fax no: ____________________ E-mail add: ____________

Date: ____________________