ACT Government

ACT FIRE & RESCUE

COMMUNITY FIRE UNIT HEALTH AND WELLBEING

POLICY CFU003

JUSTICE AND COMMUNITY SAFETY DIRECTORATE
ACT EMERGENCY SERVICES AGENCY
ACT FIRE & RESCUE

NOVEMBER 2024

APPENDIX 1 – HEALTH AND WELLBEING QUESTIONNAIRE

SECTION ONE: CONTACT DETAILS	
Name:	
CFU:	
Phone:	
Emergency Contact:	
Emergency Contact Phone:	
SECTION TWO: HEALTH DETAILS	
Age:	
Date of Birth:	
Gender:	

Are you male over 35 or female over 45 and NOT used to VIGOROUS exercise?	Y	N
Is there a family history of heart disease, stroke, raised cholesterol or sudden death?	Y	N
Are you on prescribed medication?	Y	N
Have you given birth in the last 6 weeks?	Y	N
Do you have any infectious diseases?	Y	N
Have you been hospitalised recently?	Y	N

Are you pregnant?	Y	N
Do you have or have you had:		
Stroke	Y	N
Diabetes	Y	N
Any heart condition	Y	N
High blood pressure > 140/90	Y	N
Dizziness or fainting	Y	N
Palpitations/pain in the chest	Y	N
Asthma	Y	N
Arthritis	Y	N
Other musculoskeletal problems	Y	N
Epilepsy	Y	N
Hernia	Y	N
Gout	Y	N
Liver or kidney condition	Y	N
Stomach or duodenal ulcer	Y	N
Glandular/rheumatic fever	Y	N
Mental health issues	Y	N

Any chronic pain or major injuries in the following areas?		
Neck	Y	N
Knees	Y	N
Back	Y	N
Ankles	Y	N
Shoulders	Y	N
Elbows	Y	N
Wrists	Y	N
If you circled yes to a condition above, please give details of conditions, medications and if relevant, approximate dates cleared.		
If you circled YES to any condition above, please take this form and the Medical Practitioner Clearance form to your Medical Practitioner and ask for a written medical clearance prior to commencing the CFU Induction program or continuing your CFU membership. **If you already have a medical clearance for any conditions above, please provide evidence.**		

Medical clearance attached:	Y	N
SIGNATURE		
I recognise that the ACT Emergency Services Agency is not able to provide me with medical advice in regard to my health and that the information above is used as a guideline to the limitations of my ability to exercise. I have answered the questions to the best of my ability. Signed: ……. Date: …….. NOTE: Should you suffer an illness or condition in the future, please tell us by completing this form again.		

MEDICAL PRACTITIONER CLEARANCE

Member Name	

The above client has indicated an intention to participate in Community Fire Unit training and/or Work Capacity test. The client would like to attempt training consisting of the following:

- field work that requires complete control of all physical faculties;
- considerable walking over irregular ground and standing for prolonged periods of time;
- lifting 11 to 20 kg, including heavy items out of a trailer;
- bending, twisting, and reaching;
- dragging a charged hose over the fire ground;
- other occasional demands that may require moderately strenuous activities in emergencies over lengthy periods of time.

Please note that conditions during a fire event when the unit is likely to be stood up will be hot, smoky and at a heightened stress level. Please take this into consideration when signing this clearance.

Can you please assess this client to see that they are a suitable candidate to complete the above assessment, and if required, list any recommendations regarding the client's exercise limitations.

This client is able to undertake the training stated above.	☐
This client is not able to undertake the training stated above.	☐

Recommendations:

Name of Medical Practitioner			
Contact Number		Provider Number	
Signed and Date			

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