ROCKY VIEW COUNTY

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MEDICAL CLEARANCE REQUEST

Dear Physician:

The patient who has presented you with these forms is currently seeking employment in Rocky View County Fire Services. As a requirement, applicants must demonstrate a minimum level of fitness and adequate sensory and motor abilities. We establish this minimum level as firefighting and emergency response is a physically and psychologically demanding job.

Fitness requirements can be judged against criteria that have been determined to be bona fide occupation requirements. Based on these requirements, an industry fitness test has been established and involves the following tasks done in series over a maximum of 10 minutes and 20 seconds:

Event #1: Ascending Stairs - 3 minutes, 60 steps/minute, with 25 lb weighted vest
Event #2: Hose Drag - 100 feet
Event #3: Equipment Carry - 75 feet
Event #4: Ladder Raise and Extension - (2) 24 foot ladders
Event #5: Forcible Entry - 10 pound sledgehammer, multiple strikes 39" off the ground
Event #6: Search - crawl through 3'x4' tunnel with obstacles for 64 feet
Event #7: Rescue - drag 165 pounds for 70 feet
Event #8: Ceiling Breach and Pull - repeatedly push up 60 lb door in the ceiling and pull down 80 lb door in ceiling

Experience has demonstrated that this type of physical testing elicits a near maximum heart rate in all participants and causes elevated blood lactate levels as anaerobic effort is undertaken. Please consider all relevant information in assessing his or her ability to safely undertake these types of tasks.

Please record the results of your assessment on the attached form entitled Medical Opinion – Clearance and return the completed forms to the patient. Any costs related to the completion of these forms are the sole responsibility of the applicant.

Thank you for your help and cooperation.

Rocky View County

MEDICAL OPINION – CLEARANCE

Applicant's name: _____

In your professional opinion do you consider this applicant to be fit to take part in the physical activities described in the letter attached to this form? (Please circle yes or no)

YES NO

COMMENTS:

Date: _____

Physician's Signature: _____

Physician's Name (Print): _____

Clinic Stamp:

PLEASE RETURN COMPLETED FORM TO APPLICANT

_____ _____

Applicant Name (Print) Applicant Signature