## **Firefighter Applicant Instruction Sheet**

## **Other Chronic Health Condition**

Any applicant:

- With a health condition;Any respiratory condition other than asthma; or,
- Taking any prescribed medication, •

**must** bring in the following documentation on the day of their pre-placement medical assessment.

#### Instructions for applicant:

- 1. Bring the information from the checklist to your pre-placement medical assessment.
- 2. Please **do not** include the medical information requested with your application form as it contains personal and confidential medical information.
- 3. Documentation and test results must be completed within the last 6 months from the pre-placement medical assessment date unless otherwise stated in the Medical Forms. (For example, if the medical assessment is scheduled for January 6, 2016, all your required documents must be dated July 6, 2015 or later.)
- 4. If you have Diabetes Mellitus, Epilepsy/Seizures, Asthma, or on an Insulin Pump, please refer to the specific medical forms found on the "Firefighter Recruitment Medical Assessment" web page.

### Checklist:

Note: Please download and print the Essential Job Tasks and provide to the physician that will be completing this form for you.

Firefighter Applicant: Other Chronic Health Condition Medical Form (attached form). This form must be completed by your treating physician within the last 6 months from the pre-placement medical assessment date.

## Firefighter Applicant Other Chronic Health Condition Medical Form

Any applicant with a health condition that is not specifically listed (e.g. diabetes mellitus, asthma, seizure/epilepsy or on insulin pump) with its own required instructions and forms, must bring in the following documentation on the day of their pre-placement medical assessment.

# This form must be completed by the applicant's treating physician <u>within the last 6 months</u> from the applicant's pre-placement medical assessment date.

#### **Applicant Information**

Last Name	First Name	Initial	Date of Birth (YYYY/MM/DD)
Address	City	Province	Postal Code

## **Physician Information**

Name of Physician	Specialty	Date of Examination (YYYY/MM/DD)
Address of Physician		Phone Number

1. What is the applicant's diagnosis?

- 2. What is the status of this applicant's health condition (e.g., clinical history, treatment plan, response to treatment, compliance with treatment, complications from the condition and/or treatment, prognosis of the condition)?
- 3. Please attach all relevant consultation reports and/or investigation results.

Physician Signature