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 above named 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 certify 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 : ……

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 Marital status : ☐ Single ☐ Married

☐ Chinese

☐ Indian

☐ Others

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 thefollowing 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 (include IHD, Heart failure) or Arrythmia	☐	☐	
iii)	Congential heart disease with cardiomegaly, ECG abnormality or inadequate oxygenation	☐	☐	
f.	Respiratory System			
i)	Uncontrolled asthma	☐	☐	
ii)	COAD	☐	☐	
iii)	Acute pulmonary infection (including T B)	☐	☐	

		Yes	No	Remarks
g.	Gastroitestinal 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 (include 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 (incuding cytotoxic agents, anti-coagulants or immunodepressansts)	☐	☐	
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 ☐ No ☐ Yes

H) Pemeriksaan Fizikal

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		

	Right	Left
c) Nose		

d) Throat ……

e) Skin …… f) Lymph nodes ……

4. Target organ :

	Normal	Abnormal	Other (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				
FEV 1				
FEVI 1/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 : ……

Name of clinic : ……

Fax no : ……

Date : ……

DOSH RN : ……..

Clinic tel no : ……..

E-mail add : ……..

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