

COBAR MINE MEDICAL

Date:

Prepared for our valued client:

Please find attached the medical results as requested for:

For any queries relating to this medical, please do not hesitate to contact Clinic Staff via the contact details below.

Clinic Name:	
Address:	
Contact No.:	

Pre employment medical: Periodical Medical: Buel Medical: Exit Medical:

MEDICAL PRACTITIONER PROVIDER DETAILS			
Name:		Address:	
Phone:		Fax:	
APPOINTMENT DETAILS			
First Name:		Surname:	
Date of Birth:		Contact:	
Date of Appt:		Time of Appt:	
Position:			
Information:			
Tax Invoices sent to:			
Medical Results:	<input type="checkbox"/> Audiometry <input type="checkbox"/> Blood Lead Level <input type="checkbox"/> Spirometry <input type="checkbox"/> Cholesterol <input type="checkbox"/> Chest X-Ray <input type="checkbox"/> IOL <input type="checkbox"/> REG <input type="checkbox"/> Iron <input type="checkbox"/> Full Functional Assessment <input type="checkbox"/> Selenium <input type="checkbox"/> Copper <input type="checkbox"/> Drug & Alcohol Urine (confirmation by laboratory required if non-negative)		

Assessment Details

Candidate Name:							< PHOTO ID >
was assessed on:							
for the position of:							
with company:							
	Satisfactory	Other	N/A		Satisfactory	Other	N/A
Medical history/examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Audiometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Full Functional Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spirometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Screening has been completed	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Chest X-Ray has been completed	<input type="checkbox"/> Yes <input type="checkbox"/> No		Results:	Date:			
Blood work has been completed	<input type="checkbox"/> Yes <input type="checkbox"/> No		Results Blood Lead:	ug/dL	Date collected:		
<input checked="" type="checkbox"/>	Is FIT to safely carry out the duties of the proposed employment without significant risk to self or others.						
<input type="checkbox"/>	Is FIT for the proposed employment provided they work within the following restrictions:						
<input type="checkbox"/>							
<input type="checkbox"/>	Is NOT FIT to safely carry out the duties of the proposed employment with significant risk to themselves or others						
<input type="checkbox"/>	Requires further assessment / information before risk assessment can be completed.						
<input type="checkbox"/>	<input type="checkbox"/> Request for information sent to GP <input type="checkbox"/> Musculoskeletal / Fitness Testing recommended <input type="checkbox"/> Other testing required (see below) Recommended testing:						

Instant Drug and Alcohol Results

<input type="checkbox"/>	Negative for alcohol
<input type="checkbox"/>	Negative for all drug classes as per AS/NZS 4308:2008 <ul style="list-style-type: none"> • Cocaine • Opiates • Methamphetamine • Amphetamine • Cannabis • Benzodiazepines
<input type="checkbox"/>	Positive for a breath alcohol reading of:
<input type="checkbox"/>	Requires further testing for drug class:
<input type="checkbox"/>	Requires further testing as sample did not meet the requirements of integrity testing as per AS/NZS 4305:2008

Comments/Details of modifications /other testing required:

Medical Review frequency: completed by Assessing Doctor

Review Required (Date): 3 mthly _____ 6 mthly _____ 12 monthly _____ 2 yearly _____
 Type of Review required: Expiry Date of medical:

Health Surveillance Review – completed by Company Health professional

Management plan required:

Asthma Cardio Hearing Medical Psychological Smoking Strength stretching

Other:

E.A.R Fit testing complete date:

Portacount Fit testing complete date:

Doctor's Signature:

Provider Number:

Date

Health Coordinator's Name:

Signature:

Date: