

This document should be returned by the applicant to 567 Boul. St. George Blvd, Moncton, NB, E1E 2B9

Medical Form

Applicant: _____ Program Name: _____
Date of Birth: _____ Program Location: _____

Statement Regarding Program Demands

Medavie HealthEd has a strong focus on the health and wellness of its students, as well as the safety of patients and the public at large. This medical record will aid our institution in guiding an applicant's expectations regarding the physical and psychological demands of the program and subsequent career in paramedicine, and potentially identify areas requiring accommodation. **Therefore, it is important that the applicant and their Physician review this document in detail so as to appreciate its relevance to our admission process.**

When contemplating entry the applicant and their Physician must consider any pre-existing medical conditions and/or disabilities that may prevent the applicant from successfully achieving their career goal. In turn, applicants are strongly encouraged to discuss any academic, physical, or psychological challenges with our institution, so that we may determine what, if any, form of accommodation can be afforded.

Our students participate in patient care (sometimes in uncontrolled environments) where they will be exposed to physically and psychologically exhausting events. We ask that applicants and their Physicians discuss whether they possess the physical and psychological fitness necessary to perform the bona fide occupational requirements of the paramedical profession. These requirements may be found on the Paramedic Association of Canada (PAC) website www.paramedic.ca, under the heading National Occupational Competency Profile. Specifically, the Physician and student should consider the following:

- 1) Any form of back injury
- 2) Vision or hearing loss
- 3) Neurological or muscular disorders
- 4) History of Seizures
- 5) Brain Injury
- 6) Learning disabilities
- 7) Psychological illness
- 8) Communicable diseases
- 9) Immune deficiencies
- 10) Or any other illness or injury that impacts the applicant's ability to:
 - a. read and write at a post-secondary level,
 - b. complete math computations,
 - c. communicate verbally,
 - d. practice effective problem solving, decision making and job planning
 - e. working collaboratively in an ongoing team environment
 - f. control their fine motor functions, sensory perception or physical strength

Additionally, applicants are encouraged to discuss with their Physician the requirements to successfully complete a paramedic physical abilities test (PC-PAT). This test was designed to evaluate muscular strength and endurance,

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cardiopulmonary endurance and flexibility in a practical manner. The applicant must complete all aspects of the obstacle course within nine (9) minutes to meet the requirement. If the applicant is unable to complete the course within nine (9) minutes, drops an object, or is unable to complete any single aspect of the course they will not satisfy the PC-PAT requirement. Applicants may set down objects in a controlled manner to re-adjust their grip.

The course is laid out in a straight “North – South” format with one 3-step staircase along the route. There are four (4) legs to be completed in succession with no stops in between.

The following briefly outlines the four legs of the Paramedic Physical Abilities Test:

LEG 1 (Equipment Carry Simulation):

- 1) Bilaterally pick up the 25-lbs dumbbells and follow the route straight to the marked turnaround point; turn around and return to starting position moving over the stairs.
- 2) Go to push/pull station (LEG 1 only); set dumbbells on floor and sustain one 5 sec static push and one 5 sec static pull of at least 85 lbs.
- 3) Pick up the 25-lbs dumbbells and repeat step 1.

LEG 2 (Patient Carry/Resuscitation Simulation):

- 1) Bilaterally pick up the 50-lbs dumbbells and follow the route straight to the marked turnaround point; turn around and return to starting position moving over the stairs.
- 2) Set dumbbells on the floor and perform two continuous minutes of sustained chest compressions (see important details on compressions below).
- 3) Pick up the 50-lbs dumbbells and repeat step 1.

LEG 3 (Stair Chair Simulation):

- 1) Wheel stair chair loaded with 180-lbs to the stairs and lift stair chair to the top step (partner assisted).
- 2) Lower the stair chair back to floor and continue wheeling it to the marked turnaround point; turn around and continue back to the starting position.
- 3) Turn around at the starting position and wheel the stair chair back to the marked turnaround point; turn around and wheel the stair chair to the stairs and lift the stair chair to the top step (partner assisted).
- 4) Lower the stair chair back to floor and wheel it back to the starting position.

Note: On return stair climb, change lifting position on the chair with the partner (i.e. bottom hold vs. top)

LEG 4 (Patient Carry Simulation):

- 1) Pick up the 100-lbs barbell and follow the route *bypassing the stairs* to the marked turnaround point; turn around and return to the starting point *bypassing the stairs* again.
- 2) Set down barbell and stand upright.
- 3) Pick up same 100-lbs barbell and follow the route **backwards**, *bypassing the stairs* to the marked turnaround point; turn around and return to the starting point *bypassing the stairs* again.

Medical Questionnaire

Section 1

This section of the questionnaire is to be completed by the applicant, after review of the “Statement Regarding Program Demands” found on page 1 and 2 of this Medical Form.

- 1) I have read the “Statement Regarding Program Demands.” Yes _____ No _____
- 2) I have a physical disability or learning disability. Yes _____ No _____
- 3) If you answered yes to number 2 above, have you requested a copy of Medavie HealthEd’s Disability/Medical Condition Questionnaire, so that we may collaborate to ascertain what, if any, form of accommodation is required? Yes _____ No _____

I, _____ authorize my Physician to disclose my personal health information outlined in Section 2 of this document to Medavie HealthEd. I understand that disclosure of this personal health information is for the purposes of admission consideration to the paramedic program.

Applicant Signature: _____ Date: _____

Section 2

This section of the questionnaire is to be completed by the applicant’s Physician, after review of the “Statement Regarding Program Demands” outlined above.

- 1) I have read the “Statement Regarding Program Demands.” Yes _____ No _____
- 2) The above named applicant has been under my care for _____ (indicate months or years)
- 3) Does the applicant suffer from any physical problems, which would require special consideration? Yes _____ No _____
- 4) Does the applicant suffer from any chronic physical illness/injury? Yes _____ No _____
- 5) Does the applicant suffer from any chronic emotional/psychological illness? Yes _____ No _____
- 6) Does the applicant suffer from any communicable illness? Yes _____ No _____
- 7) Does the applicant suffer from any form of skin disease? Yes _____ No _____
- 8) Does the applicant suffer from any cardiovascular disease that requires special consideration? Yes _____ No _____
- 9) Does the applicant suffer from any respiratory disease that requires special consideration? Yes _____ No _____
- 10) Does the applicant suffer from any musculoskeletal disease that requires special consideration? Yes _____ No _____

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11) Does the applicant suffer from any neurological disease that requires special consideration? Yes ____ No ____

12) Does the applicant suffer from any visual impairment? Yes ____ No ____

13) Does the applicant suffer from any hearing impairment? Yes ____ No ____

14) Does the applicant suffer from any other health concern that requires special consideration? Yes ____ No ____

Comments: _____

Upon examination of the above named applicant, it is my opinion that the applicant is, (please check one):

- Medically Fit, or
- Not Medically Fit,

to complete the paramedic program considering the physical and psychological requirements indicated on page 1 and 2 of this document.

Physician Signature: _____ Date of Examination: _____

Physician Contact Information (stamp if available):

Physician Name: _____

Business Address: _____

Phone Number: _____