AS/NZS 2299
Occupational Diver Medical Fitness Certificate

I, _____, certify that
(Doctor's name)

_____
(Candidate's name)

has been assessed for medical fitness to dive in accordance with AS/NZS 2299.1:2007 and has been found—

☐ **Fit to dive/work under pressure**
☐ **Permanently unfit**
☐ **Temporarily unfit—Review date**.....
☐ **Decision pending** .....

Categories of diving for which fitness was assessed:
☐ **All occupational diving**
☐ **All except saturation**
☐ **Other**.....

Advice provided:

Comments:

I confirm that I have received formal training in the conduct of occupational diving medical examinations.

Signed.....

Doctor's name (print).....

Date .....

Candidate's signature.....

APPENDIX N

DIVING MEDICAL EXAMINATION FORMS

(Normative)

This Appendix provides examples of medical examination forms fulfilling the requirements of Clauses 8.2.2 and 8.2.3. The AS/NZS 2299 Diving Medical Examination—Medical Questionnaire is an example of a suitable form for the purposes of Clause 8.2.2. The AS/NZS 2299 Medical Examination—Findings of Examination by Doctor Trained in Underwater Medicine sets out the minimum set of information to be recorded for compliance with Clause 8.2.3. The medical examination forms in this Appendix may be copied for use by medical practitioners.

AS/NZS 2299 Diving Medical Examination—Medical Questionnaire

Please complete the following:

Surname	Given names				
Address					
Date of birth	Sex M F				
Phone (home)	Phone (work)			Phone (mobile)	
Occupation					
Most recent dive medical date					
Type of Medical					
Unrestricted—including saturation	Limited Occupational Diving—specify type				
Unrestricted—not including saturation	Recreational Diving Industry work only				
Do you participate in any regular physical activity:	Rarely	<1/week	Weekly	2–3/week	Most days
Type of physical activity:					
How many cigarettes do you smoke per day?		Have you been a smoker in the past? Yes		No	
Do you drink alcohol?	Yes	No	How many drinks per week (average)?		
Do you take any tablets, medicines or drugs?	Yes	No			
List:					
Do you have any allergies?	Yes	No			
List:					
Have you ever had any reactions to drugs, medicines or foods?	Yes	No			
List:					
Next of kin name	Relationship				
Address					
Phone number(s)					

Have you ever had, or do you now have or suffer from any of the following:		Doctor's use only
Prescription spectacles	☐ Yes ☐ No	
Contact lenses	☐ Yes ☐ No	
Eye or visual problem	☐ Yes ☐ No	
Dentures or plate	☐ Yes ☐ No	
Recent dental procedure	☐ Yes ☐ No	
Hay fever	☐ Yes ☐ No	
Sinusitis	☐ Yes ☐ No	
Nosebleeds	☐ Yes ☐ No	
Deafness or ringing noises in the ear	☐ Yes ☐ No	
Ear infections or discharge from the ear	☐ Yes ☐ No	
Giddiness or loss of balance	☐ Yes ☐ No	
Operation on the ear	☐ Yes ☐ No	
Other ear, nose or throat problem	☐ Yes ☐ No	
Severe motion sickness	☐ Yes ☐ No	
Need to take seasickness medication	☐ Yes ☐ No	
Problems with ears or sinuses when flying in aircraft	☐ Yes ☐ No	
Severe or frequent headaches	☐ Yes ☐ No	
Migraine	☐ Yes ☐ No	
Fainting or blackouts	☐ Yes ☐ No	
Convulsions, fits or epilepsy	☐ Yes ☐ No	
Unconsciousness	☐ Yes ☐ No	
Head injury or concussion	☐ Yes ☐ No	
Sleepwalking	☐ Yes ☐ No	
Severe depression	☐ Yes ☐ No	
Claustrophobia	☐ Yes ☐ No	
Mental illness	☐ Yes ☐ No	
Heart disease	☐ Yes ☐ No	
Abnormal blood test	☐ Yes ☐ No	
ECG	☐ Yes ☐ No	
Palpitations or consciousness of your heartbeat	☐ Yes ☐ No	
High blood pressure	☐ Yes ☐ No	
Rheumatic fever	☐ Yes ☐ No	
Pain or discomfort in the chest on exertion	☐ Yes ☐ No	
Shortness of breath on exertion	☐ Yes ☐ No	
Bronchitis or pneumonia	☐ Yes ☐ No	
Pleurisy or severe chest pain	☐ Yes ☐ No	

(*continued*) Page 1 of 4

Candidate's name .....

Coughing up blood or phlegm	☐ Yes ☐ No	Doctor's use only
Chronic or persistent cough	☐ Yes ☐ No	
TB	☐ Yes ☐ No	
Pneumothorax	☐ Yes ☐ No	
Frequent chest colds or flu	☐ Yes ☐ No	
Asthma or wheezing	☐ Yes ☐ No	
Need to use a puffer or inhaler	☐ Yes ☐ No	
Operation on chest, lungs or heart	☐ Yes ☐ No	
Other chest complaint	☐ Yes ☐ No	
Indigestion, acid reflux or peptic ulcer	☐ Yes ☐ No	
Vomiting blood or passing red or black bowel motions	☐ Yes ☐ No	
Recurrent vomiting or diarrhoea	☐ Yes ☐ No	
Jaundice, hepatitis or liver disease	☐ Yes ☐ No	
Malaria or other tropical disease	☐ Yes ☐ No	
Severe loss of weight	☐ Yes ☐ No	
Hernia or rupture	☐ Yes ☐ No	
Back injury	☐ Yes ☐ No	
Significant joint problem or sports injury	☐ Yes ☐ No	
Limitation of movement	☐ Yes ☐ No	
Fracture	☐ Yes ☐ No	
Paralysis or muscle weakness	☐ Yes ☐ No	
Kidney or bladder disease	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Sickle cell disease	☐ Yes ☐ No	
Bleeding problem or other blood disease	☐ Yes ☐ No	
Skin disease	☐ Yes ☐ No	
Contagious disease	☐ Yes ☐ No	
Operations	☐ Yes ☐ No	
List operations		
Females only		
Are you now pregnant or planning to be	☐ Yes ☐ No	
Do you have periods which incapacitate you or which may reduce your physical or mental performance	☐ Yes ☐ No	
Other medical history		
Admitted to hospital	☐ Yes ☐ No	
Rejected for life insurance	☐ Yes ☐ No	
Failed a medical examination	☐ Yes ☐ No	
Unable to work on medical grounds	☐ Yes ☐ No	
Any other illness or health problem	☐ Yes ☐ No	
Family history		
Family history of heart disease	☐ Yes ☐ No	
Family history of asthma or chest disease	☐ Yes ☐ No	
Diving history to date		
Approx. date of first compressed air dive		
Total hours under pressure		
Types of diving experience:		
☐ Scuba air ☐ Surface supply ☐ Saturation		
☐ Scuba mix gas ☐ Surface deco ☐ Oxygen		
☐ Hookah ☐ Bell diving		
How many dives to date		
Longest dive		
Deepest dive		
Have you ever suffered from—		
ear squeeze?	☐ Yes ☐ No	
sinus squeeze?	☐ Yes ☐ No	
decompression illness?	☐ Yes ☐ No	
headaches during or after dive?	☐ Yes ☐ No	
extreme tiredness after dive?	☐ Yes ☐ No	
Any other diving-related problems?	☐ Yes ☐ No	
If yes, specify		

I hereby authorize the examining doctor to obtain or supply medical information regarding me from or to other doctors as may be necessary for medical purposes in my personal interest.

Signed: _____ Date: _____

Candidate's name.....

AS/NZS 2299 Medical Examination—Findings of Examination by Doctor Trained in Underwater Medicine

General appearance

Visual acuity	Uncorrected	Corrected	Near vision	Colour perception	**Height**	**Weight**
Right	6/	6/			**cm**	**kg**
Left	6/	6/				

BP / **Pulse** /min **Urinalysis**

		Notes & Comments
Head, Scalp, Face, Neck	☐ Normal ☐ Abnormal	
Ophthalmoscopy	☐ Normal ☐ Abnormal	
Pupils	☐ Normal ☐ Abnormal	
Eye movements	☐ Normal ☐ Abnormal	
Visual fields	☐ Normal ☐ Abnormal	
Nose, Septum, Airway, Sinuses	☐ Normal ☐ Abnormal	
Mouth, Throat, Teeth, Speech	☐ Normal ☐ Abnormal	
Ears—external	☐ Normal ☐ Abnormal	
Tympanic membrane R	☐ Normal ☐ Abnormal	
L	☐ Normal ☐ Abnormal	
Eustachian tubes R	☐ Easily with Valsalva ☐ With difficulty/alternate manoeuvres ☐ Nil/Unsatisfactory	
(ear clearing) L	☐ Easily with Valsalva ☐ With difficulty/alternate manoeuvres ☐ Nil/Unsatisfactory	
Chest & lung fields	☐ Normal ☐ Abnormal	
Cardiac auscultation	☐ Normal ☐ Abnormal	
Abdomen	☐ Normal ☐ Abnormal	
Lymph nodes	☐ Normal ☐ Abnormal	
Posture & gait	☐ Normal ☐ Abnormal	
Spine	☐ Normal ☐ Abnormal	
Upper limbs	☐ Normal ☐ Abnormal	
Lower limbs	☐ Normal ☐ Abnormal	
Peripheral pulses	☐ Right Dorsalis Pedis ☐ Left Dorsalis Pedis ☐ Right Post Tibial ☐ Right Post Tibial	

Tendon reflexes		Absent	Weak	Mid-range	Brisk	Hyperreflexic	**Notes & Comments**
Biceps	R						
	L						
Triceps	R						
	L						
B/Rad	R						
	L						
Knee	R						
	L						
Ankle	R						
	L						

(mark line to indicate strength of reflex elicited)

(continued)

Candidate's name.....

Plantar reflexes Right..... Left.....

Sensation..... ☐ Normal ☐ Abnormal
Cerebellar functions..... ☐ Normal ☐ Abnormal

Sharpened Romberg test			
	Time stable.....(s)	☐ Very stable	☐ Major swaying/wobbles
		☐ A few minor sways/wobbles	☐ Unable to hold balance
	No. of attempts	☐ Moderately unsteady	

Emotional & psychiatric stability ☐ Normal ☐ Abnormal
Exercise tolerance..... ☐ Fitness good—History
☐ Fitness acceptable—History
☐ Exercise test requested
☐ Exercise test performed (specify type & result)
Chest X-Ray..... ☐ Normal ☐ Abnormal Date ..... Place .....
Lung function..... ☐ Normal ☐ Abnormal
Vital capacity.....
FEV_1.....
Percentage.....
Audiometry

Hearing level	Frequency, Hz							
	500	1000	1500	2000	3000	4000	6000	8000
dB (R)								
dB (L)								

Tympanometry..... ☐ Normal ☐ Abnormal ☐ Pending
Long Bone Survey..... ☐ Not indicated ☐ Recommended
Other tests..... ☐ Nil required ☐ Indicated (specify)
Other abnormalities..... ☐ Nil noted ☐ Noted (specify)
NOTES: