

Reimbursement of Medical Examination Expense Form

- Please be aware that BC Emergency Health Service will reimburse you for expenses associated with your **pre-employment medical / physical exam only** (up to a maximum of \$200). Fees for examinations required for Driver's License purposes are not reimbursed by BC Emergency Health Services.
- The doctor/clinic's invoice must state that the service is for a **BCEHS Pre-hire Medical Exam**, or we cannot accept it.
- Please note that applicants are responsible for paying for the cost of the medical exam directly to their doctor/clinic, and the cost will be reimbursed in approximately 4-8 weeks after an applicants hire date.
- **Upon your start date, please complete this form and return by mail (do not email) along with your paid receipt and the invoice stating payment received, to the address below. Please include your employee ID number.**

Medical Examination Reimbursement Amount

Please print name & PHSA employee ID number

Please print Mailing Address

Signature

Date Signed

ENSURE YOUR ORIGINAL RECEIPT & INVOICE IS ATTACHED

MAIL TO:

Talent Acquisition, BCEHS Recruitment (Medical Reimbursement)
Provincial Health Services Authority
200 – 1333 W Broadway
Vancouver, BC
V6H 4C1

Physician Information and Medical Consent Form

Being a Paramedic is a physically demanding vocation. As a means of objectively assessing the suitability of candidates applying for a paramedic position with the British Columbia Emergency Health Service, each applicant will be required to pass a standardized job-related physical capacity assessment that includes a sub-maximal cardiovascular fitness assessment, muscular strength and endurance assessments and joint range of motion assessments.

The medical readiness form below indicates that it is your professional opinion that this candidate is physically fit enough to undertake this test.

The candidate is to present this completed form before admission to the physical capacity assessment.

Applicant Name _____

I have examined _____ and find

him/her to be suitably healthy and fit to undertake the physical capacity assessment.

Physician's comments:

Date: _____ Physician's Name: _____

Physician's Signature: _____

Telephone Number: _____

MEDICAL EXAMINATION
(to be completed by examinee)

IDENTIFICATION *	DATE	PLACE OF EXAM	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	AGE
SURNAME	GIVEN NAMES		SOCIAL INSURANCE NUMBER		
ADDRESS				TELEPHONE NUMBER	
				Home: _____	
				Bus.: _____	
OCCUPATION APPLIED FOR					
FAMILY PHYSICIAN			DATE OF LAST VISIT	TELEPHONE NUMBER	

PERSONAL HISTORY * Do you have or, have you had, any illness or injury which might interfere with your ability to safely and effectively under take employment in the above occupation? YES NO

The following may assist your response

	"X" appropriate column if you have ever been treated for any of the following:			The following may assist your response	
	Yes	No		Yes	No
1 Emotional illness			20 Constipation / diarrhea		
2 Alcohol or drug addiction			21 Jaundice / hepatitis		
3 Sleep disturbance			22 Kidney or bladder infection		
4 Fainting or dizziness			23 Kidney stone		
5 Head injury			24 Diabetes		
6 Frequent or severe headaches			25 Back trouble		
7 Seizures - epilepsy			26 Joint pain / swelling / stiffness		
8 Eye problems			27 Fractures or dislocations		
9 Hearing loss / ear infection			28 Excessive fatigue		
10 Frequent nosebleeds			29 Bleeding / anemia		
11 Asthma / wheezing			30 Skin problems		
12 Frequent cough / sputum			31 Have you had any surgery, serious illness or injury requiring hospitalization?		
13 Shortness of breath			32 Have you a medical condition persisting from childhood?		
14 Chest pain / palpitations			33 Have you used prescribed medication for more than one week?		
15 High blood pressure			34 Have you any blood borne diseases?		
16 Heart disease					
17 High cholesterol					
18 Weight change more than 5 kg.					
19 Stomach disorder / indigestion					

ALLERGIES *	IMMUNIZATIONS *	CHEST X - RAY	CURRENT MEDICATIONS: *
_____	<input type="checkbox"/> Influenza _____	Date of last Chest X-Ray _____	_____
_____	<input type="checkbox"/> Tetanus _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	_____
_____	<input type="checkbox"/> Hepatitis B _____		_____
_____	<input type="checkbox"/> TB _____		_____
_____	<input type="checkbox"/> Polio _____		_____
_____	<input type="checkbox"/> Diphtheria/Pertussis _____		_____
_____	<input type="checkbox"/> MMR _____		_____
_____	<input type="checkbox"/> Other _____		_____

WORK HISTORY *	FAMILY HISTORY *																																						
Previous jobs. (Start with the most recent)	Indicate if any of your parents, grandparents, brothers, sisters or children have suffered from the following prior to the age of 65?																																						
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>YEAR</th> <th>From</th> <th>To</th> <th>Location</th> </tr> </thead> <tbody> <tr><td>Job # 1</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Job # 2</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Job # 3</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Job # 4</td><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>	YEAR	From	To	Location	Job # 1	_____	_____	_____	Job # 2	_____	_____	_____	Job # 3	_____	_____	_____	Job # 4	_____	_____	_____	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr><td>Diabetes</td><td></td><td></td></tr> <tr><td>Cancer</td><td></td><td></td></tr> <tr><td>Heart Disease/High Blood Pressure/Stroke</td><td></td><td></td></tr> <tr><td>Emotional illness</td><td></td><td></td></tr> <tr><td>Other</td><td></td><td></td></tr> </tbody> </table>		Yes	No	Diabetes			Cancer			Heart Disease/High Blood Pressure/Stroke			Emotional illness			Other		
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In your previous jobs were you ever exposed to the following hazards? (Check as many as required)																																							
<input type="checkbox"/> Asbestos / Silica <input type="checkbox"/> Smoke / Dusts <input type="checkbox"/> Heavy elements (Lead, Arsenic, Cadmium, etc.) <input type="checkbox"/> Solvents <input type="checkbox"/> Noise	<input type="checkbox"/> Vibrations <input type="checkbox"/> Cold / Excessive heat <input type="checkbox"/> X-Rays <input type="checkbox"/> Radio-activity <input type="checkbox"/> Others (specify): _____																																						
Were you required to wear protective equipment? If yes please describe: _____																																							
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	Tobacco _____																																						
	Alcohol _____																																						
	Coffee _____ / Tea _____																																						
	Exercise _____																																						

I certify that the above information is true and complete to the best of my knowledge _____ Signature of examinee _____ Date _____

