ROCKY VIEW COUNTY
Cultivating Communities

TEL 403·230·1401
FAX 403·276-1407

911·32 Ave NE | Calgary, AB | T2E 6X6
www.rockyview.ca

MEDICAL CLEARANCE REQUEST

Dear Physician:

The patient who has presented you with these forms is currently seeking employment as a firefighter/captain with Rocky View County. As a requirement, applicants must demonstrate a minimum level of fitness and adequate sensory and motor abilities. We need to establish this minimum level as firefighting and emergency response is a physically and psychologically demanding job.

Fitness requirements can be judged against the criteria that have been determined to be bona fide occupation requirements. This test involves the following tasks done in series over a maximum of 17 minutes (20 minutes including 30 second rest periods between each event). All test elements are completed while wearing full firefighting gear and using breathing apparatus (approximately 25 lbs).

Event #1: 10 Minute Ascending and Descending Stairs
Event #2: Dummy Drag – 150 lb dummy over 144 feet
Event #3: Foam Pail Carry – lift 2-35 lb objects and carry 144 feet
Event #4: 24' Ladder Raise and Shoulder Press
Event #5: Hose Raise and Lower in Tower – 20 lb weight, 3rd floor height
Event #6: Sledge Hammer – 10 lb hammer, 20 strikes of a tire
Event #7: Hose Drag – 100 feet

Experience has demonstrated that this type of physical testing elicits a near maximum heart rate in all participants and causes elevated blood lactate levels as anaerobic effort is undertaken. Please consider all relevant information in assessing his or her fitness.

Please record the results of your assessment on the attached form entitled Medical Opinion – Clearance and return the completed forms to the patient. Any costs related to the completion of these forms are the sole responsibility of the applicant.

Thank you for your help and cooperation.

Rocky View County

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MEDICAL OPINION – CLEARANCE

Applicant's name: _____

In your professional opinion do you consider this applicant to be fit to take part in the physical activities described in the letter attached to this form? (Please circle yes or no)

YES NO

COMMENTS:

_____

_____

_____

Date: _____

Physician's signature: _____

Physician's name (print): _____

Clinic stamp:

PLEASE RETURN COMPLETED FORM TO APPLICANT

_____ _____

Applicant name (print) Applicant signature