APPENDIX 3: OCCUPATIONAL DIVER MEDICAL ASSESSMENT QUESTIONNAIRE

Occupational divers in New Zealand must undergo a full diving medical examination every 5 years, or as determined by the Diving Medical Consultant (DMC). The full diving medical examination must be carried out by a Designated Diving Doctor (DDD), the completed medical examination results must be forwarded within 28 days to Diving and Hyperbaric Medical Services (PO Box 32139, Devonport, Auckland). If deemed unfit to dive, the DMC will request further evaluation by an appropriate medical specialist.

During the interim four-year period, an Occupational Diver Medical Assessment Questionnaire must be completed annually by the diver. This questionnaire is part of the medical assessment of fitness for occupational diving. It is regarded as an acceptable assessment by WorkSafe New Zealand for medical clearance of occupational divers provided a full medical examination is completed every 5 years (or as determined by the DMC). This meets the requirement of AS/NZS 2299 Part 1 2007 as well as the Health and Safety in Employment Regulations (regulation 49).

The questionnaire can be filled in online, go to www.divemedical.co.nz to register or printed and mailed as detailed below.

The questionnaire and (and tests or full medical examination if required) must be mailed within 28 days to Diving and Hyperbaric Medical Services, PO Box 32139, Devonport, Auckland together with a cheque for the processing fee of $97.00 incl GST.

Cheques should be made payable to "Diving and Hyperbaric Medical Services". If you have previously obtained a medical clearance with Diving and Hyperbaric Medical Services you are now able to complete this questionnaire, scan and up-load your full medical examination and tests if required and make payment online at www.divemedical.co.nz. If the applicant is deemed fit to dive, a medical clearance will be issued to the diver via email. Most assessments will be processed within 10 working days unless further investigations are required. Any queries about this process should be in writing to the above postal address, or emailed to, divemeds@gmail.com.

The full medical must be completed in the year of application for a certificate of competency, or renewal of a certificate of competency. A medical clearance (within the last six months) will be required at the time of applying for a certificate of competency.

Where a diver suffers an accident, illness, a change of medication, or any medical circumstance which is likely to affect their medical fitness to dive, a new full medical assessment must be completed prior to recommencing work.

Diving Hyperbaric Medical Services may also consider an appropriate medical clearance obtained overseas as part of this process. This should be discussed directly with Diving Hyperbaric Medical Services by email divemeds@gmail.com.

Surname:	Usual diving doctor:
First names:	Usual family doctor:
Postal address:	Usual employer:
	Mobile number:
E-mail address:	Date: DD / MM / YEAR
Phone number:	
Date of birth: DD / MM / YEAR	
Diver occupation:	

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WORKSAFE NEW ZEALAND
PO Box 165, Wellington, 6140
www.worksafe.govt.nz
0800 030 040

Please answer the following questions with 'yes' or 'no' (in most cases) in PEN

1. How many compressed gas underwater dives have you made in the last year?

- Beyond 30 metres?
- Using mixed gases?
- Using: Nitrox
- Heliox
- Trimix
- Other

2. For how many years have you engaged in compressed gas diving?

3. Have you had any health problems that are related to underwater diving (including decompression illness)?

- No
- Yes

If yes, please provide details (including dates, treatment received and location of any treatment facilities):

DD / MM / YEAR

4. Have you had or do you have any physical, psychological (eg fears of confined spaces or water) or mental health conditions that may affect your ability to undertake compressed gas underwater diving?

- No
- Yes

If yes, please provide details:

5. Have you been hospitalised (including mental health facilities)?

- No
- Yes

If yes, please provide details

6. In the past 12 months have you had :

- Chest x-ray?
- Lung function test?
- Challenge tests for asthma?
- Hearing tests?

If yes, please provide details (including why the tests were done):

7. Are you taking any medication on a regular or occasional basis?

- No
- Yes

If yes, please provide details:

8. Are you allergic to any agents, drugs or substances?

- No
- Yes

If yes, please provide details:

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MAHI HAUMARU AOTEAROA

9. **What other occupations or sports do you take part in?**

10. **(Females only) Are you or may you be pregnant?**

11. **Do you or have you had asthma?**

○ No ○ Rarely ○ Often

If yes, please provide details:

12. **Do you experience any breathlessness, chest pain or tightness, or wheeze or cough during exercise or at night?**

○ No ○ Yes

If yes, please provide details:

13. **Have you had any problems with your eyes (difficulty seeing clearly or distinguishing between colours)?**

○ No ○ Yes

If yes, please provide details:

14. **Have you had any problems with ringing in your ears (tinnitus) or with a sense of spinning (either you spinning around or the sense of the room spinning around you)?**

○ No ○ Rarely ○ Often

15. **Have you had any neck, back, bone or joint problems?**

○ No ○ Yes

If yes, please provide details:

16. **Do you or have you experienced numbness and tingling and/or weakness or heaviness in your limbs after diving?**

○ No ○ Yes

If yes, please provide details:

17. **Do you or have you experienced any form of recurring headaches?**

○ No ○ Yes

If yes, please provide details:

18. **Do you or have you experienced any form of fits, fainting, turns, epilepsy or convulsion?**

○ No ○ Rarely ○ Often

If yes, please provide details:

19. **Do you or have you experienced any difficulty with your ears when diving or flying?**

○ No ○ Yes

If so, please provide details:

20. **Do you or have you experienced any form of chronic sinusitis?**

○ No ○ Yes

If yes, please provide details:

21. **Do you or have you ever suffered any problems with hearing?**

○ No ○ Yes

If yes, please provide details:

22. **Do you or have you experienced any state of confusion or impaired conscious level?**

○ No ○ Yes

If yes, please provide details:

23. **Have you ever suffered from a head injury which caused you to lose consciousness?**

No Yes

If yes, please provide details:

24. **Do you have diabetes mellitus?**

No Yes

If yes, please provide details, especially noting the medication that you take and if you have had any reactions or unwanted outcomes from

25. **Have you had any blood or urine tests for sugar?**

No Yes

If yes, please provide details:

26. **Do you experience ankle swelling?**

No Yes

If yes, please provide details:

27. **Have you experienced unusual beating sensations (palpitations) in your chest?**

No Yes

If yes, please provide details:

28. **Have you suffered any heart disease or blood pressure problem?**

No Yes

If yes, please provide details:

29. **Have you suffered any bone fractures or joint injuries/disease?**

No Yes

If yes, please provide details:

30. **Have you recently had any form of tooth pain related to diving?**

No Yes

If yes, please provide details:

31. **Do you or have you had an illness which affects your nervous system (brain and/or nerves)?**

No Yes

If yes, please provide details:

32. **Do you have any conditions affecting your blood in any way (eg anaemia, problems with clotting, or haemoglobin disorders)?**

No Yes

If yes, please provide details:

33. Do you currently smoke?

○ No ○ Yes

If so, how many cigarettes/day?

Have you ever smoked?

If so, how many years did you smoke for?

How many years since you stopped?

34. Do you or have you suffered from any form of respiratory illness (eg pleurisy, coughing up blood), or injury (eg collapsed lung — pneumothorax) or infection (eg pneumonia or TB)?

○ No ○ Yes

If yes, please provide details:

35. Have you undergone any surgery which involved your chest?

○ No ○ Yes

If yes, please provide details:

36. Do you suffer sea sickness

○ No ○ Yes

If yes, do you ever take medication for the problem?

○ No ○ Yes

If yes, please provide details:

37. Approximately how many standard-sized alcoholic drinks do you consume per week?

○ 0-10

○ 0-20

○ 12-30

○ more than 30

38. Do you currently use, or have you in the past 6 months used recreational drugs?

○ No ○ Yes

If yes, please provide details:

39. Are there any other medical details that affect your diving

○ No ○ Yes

If yes, please provide details:

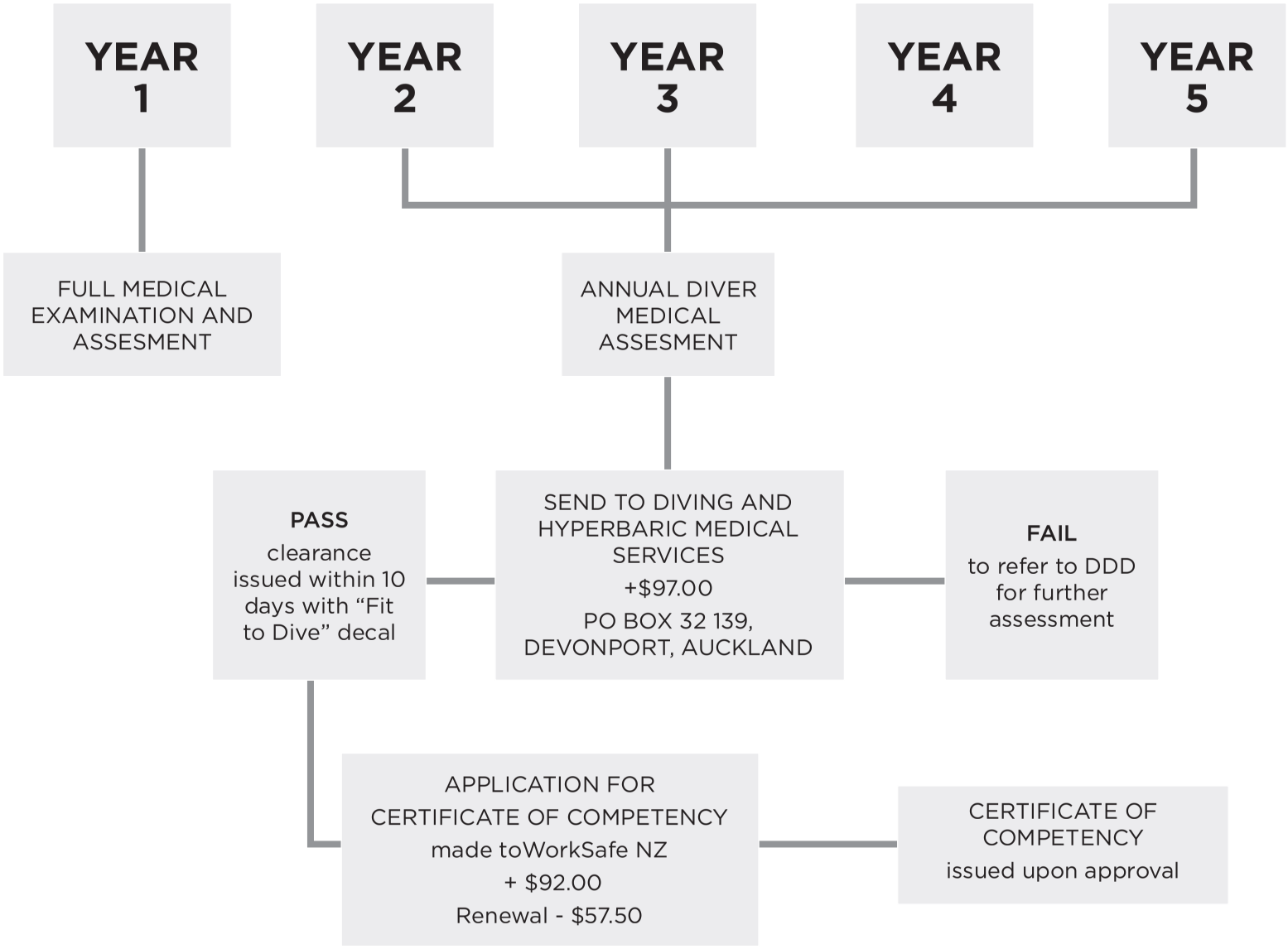
CONSENT: I understand that access to data contained in my individual occupational diver's medical record is restricted to myself and authorised WorkSafe New Zealand and medical personnel. I also understand that this data may be used, once de-identified, for research which is specifically designed to detect any increased occupational risks and which has been approved by an accredited ethics committee. I have the right to know the results of any such research. Any other individual or organisation seeking access to my individual details must first provide WorkSafe New Zealand with written proof of my approval.

DECLARATION

I hereby declare that, to the best of my knowledge, the above details are true and correct. I also understand my employer and I are required to inform WorkSafe New Zealand and a NZ Registered Designated Diving Doctor of any accident or illness that may affect my Diving Fitness. (Refer 3.1 of the Guidelines for Occupational Diving)

Signed:

Date: DD / MM / YEAR



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This completed form should be sent to:
Technical Support Services, WorkSafe New Zealand
PO Box 165, Wellington 6140
Email: technicIservices.notification@worksafe.govt.nz
Phone: 04 901 4972 or 0800 030 040

COC: Certificate of Competency
DDD: Designated Diving Doctor
Diving Hyperbaric Medical Services:
PO Box 32 139, Devonport, Auckland.
email: divemeds@gmail.com
web: www.divemedical.co.nz

Acknowledgement: Thanks to Otago Dive