ANISHINABEK POLICE SERVICE

EMPLOYMENT VISION REPORT

APPLICANT NAME _____

VISION REQUIREMENTS:

Uncorrected Visual Acuity - At least 20/40 (6/12) with both eyes open
Corrected Visual Activity - At least 20/20 (6/6) with both eyes open
Farsightedness - The amount of hyperopia must not be greater than +2.00 D, spheroequivalent in the least hyperopic eye.
Depth Perception - Stereo acuity of 80 seconds of arc or better
Lateral Phoria "Far" - In excess of 5 eso or 5 exo, requires additional information from an eye care professional, which documents that the person is unlikely to experience double vision when fatigued or functioning in reduced visual environments
Lateral Phoria "Near" - In excess of 6 eso or 10 exo, requires additional information from an eye care professional, which documents that the person is unlikely to experience double vision when fatigued or functioning in reduced visual environments
Colour Vision - Pass Farnsworth D-15 without any colour corrective (e.g. X-Chrom, Chromagen) lenses
Peripheral Vision - Peripheral visual field limits with a 5 mm white target at 33 cm (or a target with simular angular size with respect to the candidate's viewing distance) should be no less than the limits given below. In addition, no blind spots should be present within these limits other than the physiological blind spot.

Limits for the various meridians are:

Temporal	(0° meridian)	75°
Superior-temporal	(45° meridian)	40°
Superior	(90° meridian)	35°
Superior-nasal	(135° meridian)	35°
Nasal	(180° meridian)	45°
Nasal-inferior	(225° meridian)	35°
Inferior	(270° meridian)	55°
Inferior-temporal	(315° meridian)	70°

PARTICULARS OF EXAMINER

NAME _____ **PHONE** _____
ADDRESS _____
QUALIFICATIONS _____

I certify that the above named applicant meets or exceeds all of the above vision requirements.

SIGNATURE _____

ANISHINABEK POLICE SERVICE

HEALTH EXAMINATION REPORT

Position Applied For			**Today Date** Year _____ Month _____ Day_____
Sex ☐ **Male** ☐ **Female**			**Date of Birth** Year _____ Month _____ Day___
Surname		**Given Names**	
Address	**City/Town**	**Postal Code**	**Telephone**
Family Doctor	**Address**		**Telephone**

CONSENT

I, _____, hereby consent to the release of the information gathered in respect of this medical examination to the Anishinabek Police Servcie to be used for the purpose of assisting in determining suitability for employment.

Date: _____

Witness: _____ **Signature:** _____

Personal History

Spouse

Children (Number and State of Health)

Military Services ☐ Yes ☐ No Disability Pension ☐ Yes ☐ No

Immunization

TB Skin	☐ Yes ☐ No	Date of Last Test	Result	Chest x-ray	☐ Yes ☐ No	Date of Last One	Reason

Past Health History

Past Illness (including Childhood Illnesses, High Blood Pressure, Heart Disease, Diabetes, Thyroid Disease, Cancer)

Operations

Accidents

Hospitalizations

Allergies

Medications (Prescription - Other)

Habits

	Yes	No	Quantity
Cigarettes - Tobacco			
Hard Drugs			
Alcohol			
Coffee/Tea			

Family History

	Mother	Father	Other			Mother	Father	Other			Mother	Father	Other
Tuberculosis					Epilepsy					Skin Disorder			
Diabetes					Blood Disorders					Kidney Diseases			
Cancer					Asthma					High Blood Pressure			
Nervous Disorders					Hay Fever					Heart Disease			
Glaucoma					Alcoholism								

Other Details : (include other Diseases)

Health History (Continued) Functional Enquiry

A. Current Health Status ☐ Good or ☐ Bad

B. Are you suffering from or under treatment for any disease now? ☐ Yes ☐ No Name _____

C. Do you have a pre-existing illness or injury that would prevent you from doing the essential duties of the job?

☐ Yes

☐ No

D. Do you now or have you ever suffered from any of the following

	Yes	No		Yes	No		Yes	No
Recent Change in Weight			Allergy to Drugs			Constipation - Diarrhea		
Recent Fatigue or Weakness			Anemia - Blood Conditions			Bloody or Black Bowel Movement		
Head Injury or Concussion			Breast Problems - Lumps			Haemorrhoids		
Fainting Spells or Dizziness			Night Sweats			Hernia or Rupture		
Epilepsy or Convulsions			Chronic Cough			Kidney or Bladder Trouble		
Frequent Headaches			Coughing - Mucus or Blood			Infections, or Stones		
Migraine			Lung Disease i.e.. TB, Pneumonia			Frequently Passing Water		
Ear Aches or Infections			Bronchitis, Emphysema			Pain - Burning Discharge		
Ear Noises or Deafness			Shortness of Breath			Urine - Bloody or Discolored		
Eye Irritation or Infection			Palpitations			Neck or Back injury or Pain		
Serious Eye Problems			Heart Trouble			Low Back Pain		
Vision Problems			Chest Pain - Pressure - Tightness			Varicose Veins - Phlebitis		
Nose or Throat Problems			Swelling of the Ankles			Numbness or Tingling		
Frequent Nose Bleeds			Rheumatic or Scarlet Fever			Rheumatism or Arthritis		
Sinus Trouble			Ulcers - Stomach Trouble			Other Joint or Muscle Problems		
Frequent Colds/Sore Throats			Indigestion - Nausea - Vomiting			Foot Problems		
Tooth or Gum Trouble			Vomiting Blood			Problems Sleeping		
Skin Rashes; Itchiness, Burning			Liver Trouble - Jaundice			Nervous Trouble Breakdowns		
Skin - Moles - Tumor			Abdominal Pain			Menstrual Problems		
Hives - Hay Fever Asthma			Bowel Trouble			Have You Any Restriction on Physical Activity		

Explain "yes" answers

PHYSICIAN'S EXAMINATION

SURNAME **GIVEN NAME** **DATE**

GENERAL	Appearance		LABORATORY	Haemoglobin	
	Mental Status			Urine (Dip Stick)	Alb. Sugar
	Height	cm		Other Tests If Indicated	
	Weight	Usual Present			
	T.P.R.	T. P. R.	CHEST X-RAY	Date	
EYES	Reaction	Accom. Light	Pulmonary Function Tests (if indicated) Date		
	Pupils	Equal Unequal			
	Fundi		ECG (if appropriate)		
	Fields of Vision				
VISION	Color (Test Used)		Health Education (Specify)		
		Near Far			
	Without Glasses	R / L / R / L /			
	With Glasses	R / L / R / L /	Immunization Given (Specify)		
EARS	Hearing	R L			
	Drums	R L	THIS SPACE FOR ADDITIONAL INFORMATION AND REMARKS		
	Other	R L			
MOUTH TONGUE	Gums				
	Dental/Hygiene				
	Other				
THROAT-TONSILS					
NECK	Movement				
	Pain-Tenderness				
	Other				
THYROID					
LYMPH NODES					
BREASTS					
HEART	Size				
	Rhythm				
	Murmurs				
	Carolid Bruits				
BLOOD PRESSURE	Before Exercise				
EXCERISE AS APPROPRIATE (ESPECIALLY POLICE APPLICANTS)	Heart Rate Resting				
	After Exercise				
	1 Minuter After				
	2 Minutes After				
	Exercise (e.g. 20 step ups)	Time EGG.			
CHEST	Type				
	Resonance				
	Activenitious Sounds				
ABDOMEN	Appearance - Scars				
	Tenderness				
	Masses/Organs				
	Bowel Sounds				
HERNIA	Inguinal				
	Femoral				
	Other		**Impressions**	**Healthy**	**Health Problems**
RECTAL					
HAEMMORHOIDS			**Fit For Job** ☐	**Fit with limitations** ☐	**Unfit** ☐
PROSTATE/PELVIC	If Appropriate				
DEFORMITIES			**Please describe problems/limitations**		
EXTREMITIES	Arms/Hands				
	Legs/Feet				
	Varicose Veins	R L			
JOINTS	Upper (Espec. Shoulders)		Examining Physician (Please Print Name)	**Phone**	
	Lower (Espec. Knees)				
SKIN			**Address**		
SPINE	Mobility				
	Pain/Tenagmes				
	Deformity				
NERVOUS SYSTEM	General		**SIGNATURE**		
	Tendon Reflexes	R L			