Appendix No. 4: Details of Medical Fitness for Occupational Divers (COP)

First Supplement:

Scope of Initial Medical Examination for Evaluating the Medical Fitness of an Occupational Diver

1. Medical history (anamnesis) according to the form appearing in the Third Supplement, and physical examination according to the same form.
2. Resting ECG (12 leads).
3. Exercise ECG (stress test).
4. Hearing examination (audiometry), including pure-tone testing by bone and air conduction, as well as SRT testing.
5. Eye examination by an ophthalmologist, including visual acuity, fundoscopy, and intraocular pressure.
6. Chest X-ray (front and lateral views).
7. Complete blood count (CBC).
8. General urine test.
9. Fasting blood glucose.
10. Liver and kidney function tests, including urea and creatinine.
11. Spirometry – lung volumes and flow measurements; flow-volume curve.
12. X-rays of long bones – recommended but not mandatory.
13. Additional tests at the discretion of the authorized physician.

Second Supplement:

Scope of Periodic Medical Examination for Evaluating the Medical Fitness of an Occupational Diver

1. Medical history (anamnesis).
2. Complete general physical examination.
3. Resting ECG (12 leads).
4. Exercise stress test.
5. Hearing examination (audiometry).
6. Eye examination by an ophthalmologist, including fundoscopy and intraocular pressure.
7. Complete blood count.
8. General urine test.
9. Fasting blood glucose.
10. Spirometry – lung volumes and flow measurements; flow-volume curve.
11. X-rays of long bones once every 5 years for divers under age 40, and once every 3 years for divers over age 40 (recommended, not mandatory).
12. Review of the diver's logbook for unusual incidents.
13. Additional tests at the discretion of the authorized physician.

Third Supplement:

Medical Questionnaire for Occupational Divers

(To be completed by the diver)

Please complete carefully and to the best of your knowledge the details in this confidential medical form, intended to assist in determining your fitness for diving. The form will be attached to your medical file at an authorized occupational medicine service.

Name: _____ I.D./Pass. No.: _____

Place of Examination: _____ Date: _____

Address: _____

Phone: _____ E-mail: _____

Previous Medical Examination Date: _____

I have previously been restricted from diving for medical reasons (details): _____

_____

_____

Have you suffered/, or do you currently suffer, from any of the following conditions?

Condition	Yes	No
Lung disease (asthma, spasmodic bronchitis, tuberculosis, chest trauma or surgery)		
Heart disease (coronary artery disease, heart defect, heart surgery)		
Vision disorders (myopia greater than 5 diopters, retinal disease, etc.)		
Diseases of the ears, sinuses, nose, throat, allergic rhinitis		
Kidney disease		
Rheumatic fever, joint diseases		
Epilepsy, fainting, loss of consciousness		
Concussion, head injury		
Psychiatric disorders, neurological diseases		
Diabetes		
Claustrophobia, fear of heights, fear of depths		

Severe seasickness, tendency to vomit		
Chronic digestive system diseases		
Surgeries (details):		
Hospitalization (details):		
Smoker: _____ cigarettes per day		
Alcohol intoxication/drinking to excess		
Regular use of medications (details):		
Are you pregnant?		
Other (details):		

University of Haifa, 199 Aba Khoushy Ave, Mount Carmel, Haifa, Israel 3498838 אוניברסיטת חיפה, שד' אבא חושי 199, הר הכרמל, חיפה
Multi-Purpose Building, בנין רב-תכליתי,
Tel: +972-4-8240600, +972-4-8249819 | Fax: +972-4-8240493 | E-Mail: maritime@research.haifa.ac.il

גיליון בדיקה רפואית לצולל תעסוקתי

(To be filled by a physician)

	Yes	No
Eyes:		
Lungs:		
Myopia, #dioptries		
Rales		
Conjunctivitis		
Bronchospasm		
Nystagmus		
Diminished air entry		
Retinal changes		
Dullness		
Sinuses:		
X-RAY abnormalities		
Sinusitis		
Abdomen:		
Percussion sensitivity		
Liver normal		
Spleen normal		
Nose:		
Rhinitis (acute)		
Renal sensitivity		
Rhinitis (chronic)		
Other pathology		
Polyps		
Neurology		

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Deviation of septum		
Pathological findings		
Blow test abnormal		
Psychology		
Throat		
Psycho-pathology present		
Tonsillar hypertrophy		
Morphometry		
Ears		
Height:	Weight:	
Otoscopy abnormal		
Valsalva abnormal		
Body Mass Index (BMI):		
Equilibrium		
Blind walk abnormal		
Romberg abnormal		
Heart		
Murmur present (Details):		
Borders abnormal		
Heave present		
Ruffie test:		
Pulse at rest		
A=_____ Pulse immediately after 30 knee bends		
B=_____ Pulse 60 sec later		
C=_____ Pulse 120 sec later (if still high)		

_____ (A+B+C)-200/10 =		
ECG normal: (Details):		

ממצאיי בדיקות עזר

(To be filled by a physician)

מבחן מאמץ: _____

בדיקת שמיעה (אודיומטריה): _____

בדיקת רופא עיניים: _____

קרקעיות: _____

לחץ תוך עיני: _____

ספירת דם: _____

שתן לכללית: _____

סוכר בצום: _____

ספירומטריה: _____

צילומי עצמות ארוכות: _____

בדיקת יומן הצלילה של הצולל לאירועים חריגים: _____

_____

בדיקות אחרות לפי שיקול דעתו של הרופא המורשה: _____

_____

University of Haifa, 199 Aba Khoushy Ave, Mount Carmel, Haifa, Israel 3498838 אוניברסיטת חיפה, שד' אבא חושי 199, הר הכרמל, חיפה
Multi-Purpose Building, בנין רב-תכליתי,
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Fourth Supplement:

אישור רפואי לצולל תעסוקתי

(To be filled by a physician)

תאריך: _____ שם שרות רפואה תעסוקתית מוסמך: _____

שם פרטי: _____

שם משפחה: _____

תעודת זהות: _____

כתובת: _____

עבר בדיקה ראשונית/תקופתית/מיוחדת לצורך עבודה כצולל מקצועי ונמצא:

☐ כשיר ללא הגבלות

☐ כשיר בהגבלה

☐ בלתי כשיר זמנית עד: _____

☐ בלתי כשר תמידית עד: _____

שם הרופא: _____

כתובת הרופא: _____

חותמת: _____