

Coal Mine Workers' Health Scheme - Health Assessment Form

Section 46 Coal Mining Safety and Health Regulation 2001 Form Number CMSHR 1
(Form approved by Chief Inspector under section 281 of the Coal Mining Safety and Health Act 1999)

Name (Full Given Name(s) and Family Name)

Date of Birth

Privacy Obligations

Health surveillance information is collected by the Department of Employment, Economic Development and Innovation for the purpose of identifying medical conditions or impacts on health resulting from exposure to chemical and physical agents in the coal mining industry. It is collected under the authority of Part 6 – Division 2 of the *Coal Mining Safety and Health Regulation 2001*.

The Department will not disclose this information to any person except in accordance with the Regulation. The Regulation requires that the identity of a coal mine worker is protected when information is disclosed for research purposes.

Guidance Notes for completion of Health Assessment

Employer

- Must arrange for the Health Assessment of Coal Mine Worker.
- Must complete Section 1 on page 2 which includes informing the Examining Medical Officer or Nominated Medical Adviser if: a colour vision test is required; the worker is, or may be, exposed to dust (and therefore a chest x-ray is required); and the SEG (similar exposure group) of the worker.
- Must meet the cost of the Health Assessment.

Coal Mine Worker

- Must bring photo identification to have identity checked by the Examining Medical Officer.
- Must complete Section 2 on pages 2 to 3.
- In relation to Section 2 - Work History:
 - **if the coal mine worker is commencing work** – full work history must be provided; or
 - **if the coal mine worker is already employed in the industry** – only work history since last Health Assessment is required.
- Should request the Nominated Medical Adviser provide a copy of the Health Assessment Report and an explanation.

Examining Medical Officer/ Nominated Medical Adviser

- Must check photo identification provided by the Employee.
- Must review Section 1 and Section 2 (pages 2 to 3 with the coal mine worker and comment on any abnormality).
- Must complete Section 3 on pages 4 to 6
- Must attach a separate statement if space on Form is insufficient.
- Must take advice from the employer on the requirements for a colour vision test and/or chest x-ray.
- Must **not** complete the "Section 4 Health Assessment Report" if not a Nominated Medical Adviser.
- Must, where appropriate, forward the completed Health Assessment Form (intact) to Nominated Medical Adviser.

Nominated Medical Adviser

- Must review Sections 1, 2 and 3.
- Must assess whether the Health Assessment provides adequate information to make a report on the fitness for duty of the coal mine worker.
- If the coal mine worker has an abnormal colour vision and/or hearing result affecting fitness for duty, a practical test should be arranged.
- Must complete "Section 4 Health Assessment Report".
- Must provide an explanation of "Section 4 Health Assessment Report" to the Coal Mine Worker and, where practical, secure the signature of the Coal Mine Worker on the Health Assessment Report:
- Must provide a copy of "Section 4 Health Assessment Report" to:
 - the Coal Mine Worker at the address shown on page 2; and
 - the employer.
- Must forward a copy of the complete "Health Assessment Form" (all 7 pages) to the Health Surveillance Unit of the Department of Employment, Economic Development and Innovation.
- Must maintain secure records of the Health Assessment and associated documentation.

Section 1 – Employer to complete

Name of Nominated Medical Adviser

Employer

Coal Worker's Position

Description:	
Generic SEG*:	Company SEG**:

Mine (e.g. Southern Colliery)

SEGs are groups of workers with similar exposure

* Generic SEG is sourced from the list provided by Safety & Health

** Company SEG is the employer SEG

- (a) Is the coal mine worker at risk from dust exposure (X-ray needed)? Yes No
- (b) Will the coal mine worker be working underground? Yes No
- (c) Does the coal mine worker require colour discrimination? Yes No
- (d) Is the worker at risk from occupational noise? Yes No
- (e) Is the worker at risk from hazardous chemicals? (comment) Yes No
- (f) Are there hazardous duties requiring a specific fitness assessment? (comment) Yes No

Comment

Section 2 – Coal Mine Worker to complete

2.1 Coal Mine Worker

(a) Family Name Given Name (s)

(b) Date of Birth (d) Male Female (e) Telephone:

(c) Address:

2.2 Work History (coal mine worker to refer to Guidance Notes on the coversheet)

Year		Job Title or Description	Employer
From	To		

2.3 Health-related History

- (a) Have you previously had a medical examination under this scheme? Yes No
- (b) If Yes, when was the last examination?
- (c) Have you been admitted to a hospital or undergone surgery or an operation? Yes No
- (d) Have you ever had an illness or operation that has prevented you from undertaking your normal duties for more than two weeks? Yes No
- (e) Have you ever had an injury that has prevented you from undertaking your normal duties for more than two weeks? Yes No
- (f) Are you taking any medication? Yes No
- (g) Do you use hearing protection whilst in noisy areas? Yes No
- (h) Do you currently smoke, or have you ever smoked? Yes No

(Supply details) START..... STOP TYPE QUANTITY/ DAY

Examining Medical Officer's comments on Questions 2.1 to 2.3

2.4 Have you ever suffered from, or do you now suffer from, any of the following?

	Yes	No		Yes	No
(a) Heart disease or heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	(n) Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
(b) Chest pain, angina or tightness in chest	<input type="checkbox"/>	<input type="checkbox"/>	(o) Sciatica, lumbago, slipped disc	<input type="checkbox"/>	<input type="checkbox"/>
(c) High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	(p) Neck injury or whiplash	<input type="checkbox"/>	<input type="checkbox"/>
(d) Asthma, bronchitis or other lung diseases	<input type="checkbox"/>	<input type="checkbox"/>	(q) Back or neck pain which has prevented you from undertaking full duties	<input type="checkbox"/>	<input type="checkbox"/>
(e) Abnormal shortness of breath or wheezing	<input type="checkbox"/>	<input type="checkbox"/>	(r) Knee problems, cartilage injury	<input type="checkbox"/>	<input type="checkbox"/>
(f) Deafness, loss of hearing or ear problems	<input type="checkbox"/>	<input type="checkbox"/>	(s) Fractures or dislocations	<input type="checkbox"/>	<input type="checkbox"/>
(g) Ringing noises in your ears	<input type="checkbox"/>	<input type="checkbox"/>	(t) Shoulder, knee or any other joint injury	<input type="checkbox"/>	<input type="checkbox"/>
(h) Other hearing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	(u) Hernia	<input type="checkbox"/>	<input type="checkbox"/>
(i) Disease or disorder of the nervous system	<input type="checkbox"/>	<input type="checkbox"/>	(v) Arthritis or rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
(j) Episodes of numbness or weakness	<input type="checkbox"/>	<input type="checkbox"/>	(w) Dermatitis, eczema, or skin problems	<input type="checkbox"/>	<input type="checkbox"/>
(k) Psychiatric illness	<input type="checkbox"/>	<input type="checkbox"/>	(x) Allergies	<input type="checkbox"/>	<input type="checkbox"/>
(l) Blackouts, fits or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	(y) Allergic reaction or reaction to chemicals or dust	<input type="checkbox"/>	<input type="checkbox"/>
(m) RSI, tenosynovitis, over-use syndrome or wrist strain	<input type="checkbox"/>	<input type="checkbox"/>			

2.5 Previous vaccinations and blood tests

- (a) When were you last immunised against Tetanus? Year
- (b) When were you last immunised against Hepatitis A? Year
- (c) When were you last immunised against Hepatitis B? Year
- (d) When was your last cholesterol test? Year

Examining Medical Officer's comments on Questions 2.4, and 2.5

.....

.....

.....

Coal Mine Worker's Declaration (to be witnessed by Examining Medical Officer)

I certify to the best of my knowledge that the above information supplied by me is true and correct.
 I understand that if any of the information given is knowingly false, my employment may be terminated.

Signature Date / /

Witness Date / /

3.9 Respiratory system

Litres	Observed		Predicted		Observed/Predicted %	
	(b)		(e)		(h)	
Forced exp. Vol. 1 sec- FEV ₁	(b)		(e)		(h)	
Forced vital capacity - FVC	(c)		(f)		(i)	
FEV ₁ /FVC%	(d)		(g)			

- 3.10** Spirometry (*abnormal includes FEV₁/FVC<70%*) Abnormal Normal
- 3.11** Auscultation of chest Abnormal Normal
- 3.12** (a) Was chest x-ray undertaken (as advised by employer) Yes No
- (b) Date x-ray was taken / /
- (c) Quality of film? Unsatisfactory Satisfactory
- (d) What was the result? (Also attach x-ray film to this Report) Abnormal Normal

3.13 Musculo-skeletal system

- | | Abnormal | Normal |
|-------------------------------------|--------------------------|--------------------------|
| (a) Lower back | | |
| (i) Range of movement | <input type="checkbox"/> | <input type="checkbox"/> |
| (ii) Posture and gait | <input type="checkbox"/> | <input type="checkbox"/> |
| (iii) Straight leg raising | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Neck – range of movement | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Joint movements | | |
| (i) Upper Limbs | <input type="checkbox"/> | <input type="checkbox"/> |
| (ii) Lower Limbs | <input type="checkbox"/> | <input type="checkbox"/> |
| (iii) Reflexes | <input type="checkbox"/> | <input type="checkbox"/> |

3.14 Urinalysis and Blood Sugar

- | | Present | Absent |
|-------------------------------------|--------------------------|--------------------------|
| (a) Sugar | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Protein/albumin | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Blood | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Blood sugar analysis (optional) | <input type="checkbox"/> | <input type="checkbox"/> |

3.15 Abdomen

- | | Present | Absent |
|---------------------|--------------------------|--------------------------|
| (a) Abdominal scars | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Abdominal mass | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Hernia | <input type="checkbox"/> | <input type="checkbox"/> |

3.16 Skin

- | | Present | Absent |
|--------------------------------------|--------------------------|--------------------------|
| (a) Eczema, dermatitis or allergy | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Skin cancer or other abnormality | <input type="checkbox"/> | <input type="checkbox"/> |

Examining Medical Officer's comments on Questions 3.9 to 3.16

Approved Form - Section 4 – Health Assessment Report

Coal Mine Worker's Details

Family Name	Given Name(s)	Date of birth
	/...../.....

Employer	Mine(s) (if applicable)

Examination Details

Date of Examination by EMO	Position (e.g. job title (generic))	Is the assessment for underground work?
...../...../.....		Yes <input type="checkbox"/> No <input type="checkbox"/>

As at the date of this examination, the coal mine worker:

- Is fit to undertake any position
- Is fit to undertake the proposed / current position
- Is fit to undertake the proposed / current position subject to the following restriction(s) (if necessary, outline a management program)

Is suitable for and has no condition which precludes participation in mines rescue - See Mines Rescue Medical Guidelines

For Queensland Mines Rescue Service personnel / applicants only.

Is not fit to undertake the proposed / current position because of the following restriction(s):

The duration of the restriction is: -----

Is a further review necessary? Yes Date / / No

Specify full or type of review required: -----

Was a chest x-ray taken? Yes Date / / No

As Nominated Medical Adviser I have explained the restriction / additional assessment to the worker Yes No

As Nominated Medical Adviser I have provided a copy of Section 4 to the worker (refer Note a): Yes

I have been advised of the outcome of this assessment. (Practical constraints prevent this from being a compulsory item)	Coal Mine Worker's Signature	Date / /
Nominated Medical Adviser's name and address:	NMA's Signature:	Date / /
Practice stamp		

Distribution:

- a) copy of Section 4 to coal mine worker at address shown on page 2; and
- b) copy of Section 4 to employer; or in the case of Mines Rescue membership a copy also to Queensland Mines Rescue Service, GPO Box 156, Dysart, Qld 4745; and
- c) copy of complete Health Assessment Form to Health Surveillance Unit, Department of Employment, Economic Development and Innovation, PO Box 15216, City East 4002.