

Certificate in Drilling - Non-hydrocarbon (Driller's Assistant) (Level 2) Application Questionnaire

Please answer the following questions to the best of your ability in your own handwriting.

The purpose of this questionnaire is to provide us with an insight into you level of prior learning and experiences as they relate to this programme and the industry for which you will be training.

We recognise that some of this information has already been provided on the Enrolment Form; however we would appreciate you adding it to this document as well.

Name: _____
(Surname) (First Names)

When is the best time to contact you? _____

NEXT OF KIN

(someone with a close relationship to you)

Name: _____
(Surname) (First Names)

Relationship to this person: _____

Address: _____

Telephone: Day (0) _____ Mobile (0) _____

Section A: Driver/Operator licences

Holding valid licences is a vital requirement to a successful career in the drilling industry. An important aspect of the programme is to provide a minimum level of licensing prior to working in the industry.

A1. Tick the driver/operator licences you currently hold, and when you gained them? If you cannot remember exactly when you gained the licence, please estimate.

✓	Licence	Date gained
	1	
	2	
	3	
	4	
	5	
	6	
	W	
	T	
	R	
	F	
	D	

A2 Have you ever lost your licence? No Yes

If yes, what for? _____

Lost for how long? _____

When did you lose your licence? _____. If you have lost your licence more than once, how many times have you lost it? _____

A3. Do you currently have demerit points against your licence? No Yes

If yes, how many points? ____ For what offence? _____

Note: Please provide a photocopy of your current drivers licence with this form

Section B: Industry expectations

Non - hydrocarbon drilling is a very rewarding industry in which to work. For those with the right skills, knowledge and attitudes, it can provide a pathway to supervisory, leadership and management roles, many of which are extremely well paid. It is however, an industry that requires dedication, endurance and has long hours of work.

Tick the appropriate box for each of the following questions

B1 Do you turn up for appointments on time?

Almost never Seldom Sometimes Usually Always

B2 Are you well organised?

Almost never Seldom Sometimes Usually Always

B3 Do you work well in a team?

Almost never Seldom Sometimes Usually Always

B4 The drilling industry has a zero tolerance for recreational drug use. Do you agree to be drug tested on the first day and randomly during the programme?

Yes No

B5 Are you able to work 12 hour days in isolated areas away from your home and family?

Yes No

B6 Do you have any medical or physical condition that would prevent you from operating fully in this physically demanding industry?

Yes No

If yes, describe your condition: _____

B7 What is your current situation? (i.e. occupation) _____

B8 Please list your work history

Section C: Criminal offences

There may be a need for a police check prior to being accepted for work based training. Depending on the results of this check it may impact on our ability to place you with a drilling company

C1 Have you been convicted of a criminal offence in, or are you currently being processed for a criminal offence?

Yes No

If yes, please provide details: _____

Section D: Learning

D1 Do you have any difficulties with learning e.g. remembering instructions, reading or writing? (We can provide you with assistance)

Yes No

If yes, please provide details (which will be kept confidential): _____

D2 Do you learn well in a classroom situation?

Almost never Seldom Sometimes Usually Always

D3 List all courses undertaken and state the level of achievement/certificates e.g St John First Aid? _____

D4 What attracts you to this programme? _____

Section E: Personal Information

E1 List any experience you have had with engines or small equipment eg. pumps, compressors, chainsaws

E2 List any personal interests, sporting activities, hobbies, social or community activities

E3 What are your goals in life? _____

Referees

Please provide the names of two referees who may be contacted by us (must be unrelated and have known you for 2 years or more):

Name: _____
(Surname) (First Names)

Address: _____

Telephone: Day (0) _____ Mobile (0) _____

Name: _____
(Surname) (First Names)

Address: _____

Telephone: Day (0) _____ Mobile (0) _____

Declaration	
I certify that the details provided in this form are correct. I also agree, if I am accepted for this programme, I will observe all rules and conditions as may be required by Tai Poutini Polytechnic.	
Signature: _____	Date: _____

<u>PLEASE ANSWER EACH QUESTION</u>	<u>GIVE PARTICULARS</u>
GENERAL	
1. Are you being treated by any health practitioner for any illness or injury?	YES/NO
2. In the past 12 months have you been treated by any health practitioner for any illness or injury?	YES/NO
3. Are you taking any regular medications or other remedies includes non prescription or herbal products?	YES/NO
4. Have you ever suffered any industrial or work related disease?	YES/NO
5. Have you been vaccinated for tetanus?	0–10 years ago 10–20 years ago 20 years or more
6. Do you have any allergies?	YES/NO
7. Any stomach problems or indigestion?	YES/NO
8. Eczema, Dermatitis or other skin disorder?	YES/NO
CARDIO-VASCULAR	
9. Have you ever had high blood pressure or palpitations?	YES/NO
10. Have you ever had a disorder related to circulation?	YES/NO
11. Do you have any hernia or varicose veins?	YES/NO
12. Have you had a stroke or any cerebral vascular disease?	YES/NO
RESPIRATORY	
13. Have you ever had tuberculosis, pneumonia or pleurisy?	YES/NO
14. Do you have recurrent bronchitis or asthma?	YES/NO
15. Have you had asthma in the past?	YES/NO
16. Have you ever had a chest trauma of any kind?	YES/NO
17. Do you have any “chest symptoms”? (eg wheezing , persistent cough for more than a month, abnormal breathlessness)	YES/NO

<u>PLEASE ANSWER EACH QUESTION</u>	<u>GIVE PARTICULARS</u>
18. Have you ever had sinus trouble, problems with your nose (including nose bleeds) or any surgery to the nose or throat?	YES/NO
19. If you smoke give details – How many per day? Number of years smoking?	YES/NO
20. If you no longer smoke – How long have you been smoke free?	
<i>CENTRAL NERVOUS SYSTEM</i>	
21. Have you ever had epilepsy, dizzy or fainting spells?	YES/NO
22. Do you experience any nervousness or anxiety related to working in remote areas or at night?	YES/NO
23. Have you ever had any nervous disorders?	YES/NO
<i>PSYCHO-SOCIAL</i>	
24. Alcohol - please give details. Daily drinker? Weekly drinker? Average weekly consumption?	
25. Have you had treatment for habit forming drugs?	YES/NO
26. Have you had any psychiatric disorder requiring hospital admission or treatment with medication?	YES/NO
27. Have you had sleep problems or sleep apnoea?	YES/NO
<i>MUSCULO-SKELETAL SYSTEM</i>	
28. Are you able to wear Personal Protective equipment for the duration of a full shift (upto 12 hours)? (Includes: safety boots, eye & ear protection, helmet & gloves, wet weather gear)	YES/NO
29. Have you ever had any operations to muscles or joints (for example, back, knees, hands etc). If YES, what operations and when?	YES/NO
30. Have you ever had Occupational Overuse Syndrome or other similar condition?	YES/NO
31. Have you ever had arthritis or rheumatism or other similar condition?	YES/NO

32. Do you have, or have you had, trouble with your: Back or neck? (Includes full length of back).	YES/NO
Shoulders or elbows?	YES/NO
Wrists or hands?	YES/NO
Hips knees?	YES/NO
Ankles or feet?	YES/NO
33. Are you able to undertake the following activities: Lift items (up to and sometimes exceeding 25kgs) above shoulder height? Operate machinery (up to and exceeding 25kgs) above shoulder height? Walk on uneven ground? Work in a cramped position? Kneel, stoop or crawl?	YES/NO YES/NO YES/NO YES/NO YES/NO

DECLARATION

I declare that the answers given to the above questions are, to the best of my knowledge, true in every particular. I consent to the medical provider having access to and using the information from my Health Questionnaire and medical assessment for the purposes of confirming or declining my enrolment. I authorise the result of my medical to be conveyed to TPP. I understand that if my application is confirmed this information will be kept on file at West Coast Occ.health Ltd and be used as a record of my health status at the time of commencement as a base line for further periodical health monitoring.

Signature _____

Date _____

PART B THIS WILL BE COMPLETED BY THE EXAMINING PROFESSIONAL IN GREYMOOUTH AT THE BEGINNING OF THE COURSE

Please refer to the applicants responses on Part A, the Medical Standards and Course Questionnaire supplied

PRE-COURSE HEALTH ASSESSMENT

Name: _____
(Surname) (First Names)

Height: _____ **cms** **Weight:** _____ **kg** **BMI** _____

Urinalysis: (Blood/protein/glucose) Normal / Abnormal

BSL Level _____ **Bl. Cholesterol Level** _____

Vision:

Near: Uncorrected/Corrected R _____ L _____

Distant: Uncorrected/Corrected R _____ L _____

Visual fields by hand test R _____ L _____

Hearing:

Whispered voice (6m) R _____ L _____

External auditory canals and tympani R _____ L _____

Comments related to clinical findings and Audiometry. (where supplied)

Nose:

Obstruction: _____

Septal Deformity: _____

Dental Condition:

Satisfactory _____

Needs Treatment _____

Respiratory System:

Resonance

Breath Sounds

Adventitiae

Spirometry – Comments related to clinical findings and Spirometry.(where supplied)

Cardiovascular System:

Pulse rate _____ Regular/Irregular Blood Pressure _____ / _____
Heart Sounds: Normal / Abnormal Peripheral Pulses: Normal / Abnormal
Evidence of Cardiac Enlargement? YES/NO Murmurs _____ Oedema _____
Other _____
Hernia: _____ Varicose Veins: _____

Central Nervous System

Pupils _____ Superficial Reflexes _____
Tremor _____ Others _____

Musculoskeletal System: Please record all symptoms

PLEASE PAY PARTICULAR ATTENTION TO THE SELF REPORTING QUESTIONNAIRE

General

Posture: Normal Abnormal Romberg's: Normal Abnormal

Back Movement

Forward Bend Normal Abnormal Extension: Normal Abnormal

Lateral Flexion Normal Abnormal Rotation Normal Abnormal

Neck Movement

Forward Bend Normal Abnormal Extension: Normal Abnormal

Lateral Flexion Normal Abnormal Rotation Normal Abnormal

Upper Limb

Muscle Tone Normal Abnormal Power Normal Abnormal

Co-ordination Normal Abnormal Reflexes Normal Abnormal

Joint mobility Normal Abnormal Epicondylitis Normal Abnormal

Carpal Tunnel Normal Abnormal

Lower Limb					
<u>Muscle Tone</u>	Normal	Abnormal	<u>Power</u>	Normal	Abnormal
<u>Co-ordination</u>	Normal	Abnormal	<u>Reflexes</u>	Normal	Abnormal
<u>Joint mobility</u>	Normal	Abnormal	<u>Foot Movement</u>	Normal	Abnormal

Neck movements

(forward flexion, lateral flexion, extension, rotation) Normal Abnormal

Comment

Back movements

(forward flexion, lateral flexion, extension, rotation) Normal Abnormal

Comment

Upper Limb

(Muscle tone, power, grip strength, pain on resisted actions, joint mobility, swelling, reflexes, epicondylitis, carpal Tunnel Syndrome, scars, injuries) Normal Abnormal

Comment

Lower limb

(Muscle tone, power, pain on resisted actions, joint mobility, swelling, reflexes, scars, injuries) Normal Abnormal

Comment

Musculoskeletal observation

(scars, abnormalities, leg length discrepancy, amputation etc) Normal Abnormal

Comment

Lift items (25kgs) above shoulder height YES NO

Comment re lift _____

SUMMARY

Any evidence of mechanical back pain or major joint problem? _____

Comments re Musculoskeletal Symptoms Questionnaire on Part A of form?

Comments on other findings e.g. asthma, bronchitis, cardio-vascular, physical disability etc?

MEDICAL CERTIFICATE

This is to certify that _____
of _____ was examined on _____

I have examined the above student and reviewed their questionnaire. I am satisfied that any significant health issues that could affect the student's health or safety on the course (or if employed) have been outlined.

(Signature of examining professional)

(Name and address of examining professional)