

Department of Justice and Attorney General

Youth Worker, Youth Detention Information Sheet

Please note as of the 1st July 2016 the cost of the medical has now increased to \$294.80 inc GST. Due to set I.T. rollout dates we are unable to reflect this amount in all our communications but will have this amended ASAP. If you have any questions call UHG 1300 144 143.

How do I book my pre-employment medical?

Please visit our website www.UHG.com.au to book your pre-employment medical assessment.

What do I need to complete my booking?

Pre-payment of \$294.80 (inc GST) is required via credit card to confirm your booking. We accept VISA and MasterCard.

You will be asked your preferred dates of assessment, with appointments only available Monday through Friday.

Whilst we will endeavour to meet your requirements during the booking process, it is preferable to organise an appointment 5 days prior to your preferred appointment date.

What happens once I complete my booking?

A customer service officer will confirm your appointment within 24-48 hours.

A confirmation email will be sent to your nominated email address, which will include an information pack and checklist which must be completed prior to your medical assessment.

Any questions?

Please call UHG on 1300 144 143 and speak to one of our friendly customer service officers.

Checklist

Please ensure that you have the following prior to visiting our website to book your medical.

-
- A valid VISA or MasterCard to make prepayment of \$294.80 (inc GST)

 - Three preferred dates for your medical

 - A valid email address

Department of Justice and Attorney General

Youth Worker, Youth Detention

The Youth Justice Services, Department of Justice and Attorney General take the health and safety of all our employees seriously. We want our people to be serious about their own and their co-workers health and safety. It is important to be aware that whilst your health and safety are important, your ability to perform your duties effectively can also have a serious impact on fellow workers as well as the young people in detention.

It is necessary to assess each applicant individually to consider each person's medical status and the risk of injury when performing the requirements of the position.

As part of the application process, you are required to undergo a pre-employment medical assessment. This will require you to read the attached information carefully and complete the attached questionnaire PRIOR to attending your appointment. This medical information will be used to assess your medical fitness to perform the position of youth worker.

At the time of the assessment, the doctor will review your answers and will examine you. You may be required to undress to your underclothes, so please wear appropriate loose fitting clothing.

At the completion of your appointment, the medical assessment will be forwarded to a Senior Occupational Doctor who will review the information. You may be contacted to provide further information or undergo further assessments to determine your suitability.

At the completion of this process, a determination will be made whether you are low, medium or high risk of injury if undertaking the inherent requirements of the role.

Department of Justice and Attorney General will be provided a copy of the medical assessment and the outcome. The information will be held securely and confidentially adhering to legal requirements regarding collection, access and storage of personal information.

It is important to realise that the medical assessment is one component in the selection process and that you will be considered on an individual basis taking other factors into account regarding your suitability.

Checklist

-
- Read the included documents including the Critical Job Demands, Psychological Tolerances and Other Critical Information

 - Completed the medical questionnaire from pages 5 to 13 inclusive to the best of your ability including as much detail as possible such as dates, details of condition, treatment and if appropriate, when you fully recovered from the condition to take to your appointment.

 - Provided correct contact details

 - Provide copy of your photo identification for your appointment, e.g. driver's license, passport or proof of identity card

Critical Job Demands – Youth Worker, Youth Detention

For more comprehensive report of physical job demands a full report is available

Physical Demands

R = Rare (0% to 4) of the time)

F = Frequent (34% to 66% of the time)

O = Occasional (5% to 33% of the time)

C = Constant (>66% of the time)

Position	R	O	F	C	Weight (Kg) / Force Weight height	R	O	F	C
Standing				✓	Above shoulder		✓		
Sitting		✓			Chest height		✓		
Walking over even ground			✓		Waist level			✓	
Walking over uneven ground				✓	Floor			✓	
Stairs			✓		Lift floor 5kg-10kg			✓	
Bending			✓		10kg-25kg		✓		
Balancing	✓				25kg-50kg		✓		
Climbing	✓				Lift waist 5kg-10kg			✓	
Climbing up ladder	✓				10kg-25kg		✓		
Twisting			✓		25kg-50kg	✓			
Squatting		✓			Lift chest 5kg-10kg			✓	
Kneeling		✓			10kg-25kg		✓		
Stooping		✓			25kg-50kg		✓		
Crouching		✓			Lift above head 5kg-10kg		✓		
Neck flexion		✓			10kg-25kg	✓			
Neck extension		✓			25kg-50kg	✓			
Upper limb			✓		Carrying Left			✓	
Overhead		✓			Right			✓	
Reach >30°		✓			Pulling		✓		
Forward Reach			✓		Pushing		✓		
Gripping			✓						

Assistive Equipment & Work Practices:

- Gator Electric Utility Vehicle and Utilities can be used to transport heaving equipment and supplies
- Trolleys are available to lift and transport some items.

Additional Considerations

Protective actions require staff to maintain awkward positions, potentially for long periods of time. Level of effort various depending on size and nature of young person.

Psychological Tolerances

Situation	Tolerance	Required Characteristics
<p>Threatened by one or more detainees May take place at anytime and anywhere within the facility. Threats may be towards themselves, other staff or their own family and friends.</p>	Occasional	<ul style="list-style-type: none"> • Robust & Strong mental aptitude • Resilient character • Remain calm under challenging circumstances
<p>Crime, Suicide & Attempted Suicide Events and Scenes Exposed to potential violent behavior and acts between detainees Exposed to potential violent behavior and acts towards staff members (including self) May be exposed to:</p> <ul style="list-style-type: none"> • Cadaver • Major trauma injuries • Large quantities of blood and other bodily fluids and tissue 	Occasional	<ul style="list-style-type: none"> • Robust & Strong mental aptitude • Resilient character • Remain calm under challenging circumstances • Remain calm under exposure to graphic scenes of violence
<p>Exposure to Highly Emotional Offender/s May take place at anytime and anywhere within the facility Scenario may be, but not limited to:</p> <ul style="list-style-type: none"> • Suicidal acts and thoughts • States of extreme aggression/anxiety • States of extreme depression/hopelessness 	Occasional	<ul style="list-style-type: none"> • Robust & Strong mental aptitude • Resilient character • Remain calm under challenging circumstances • Remain calm under exposure to graphic scenes of violence

Additionally, Youth Workers may be exposed to violent and traumatic scenes at times (e.g. Hangings, suicide attempts, riots), although this is rare. This requires a certain level of psychological fitness and resilience to be able to deal with these situations. If an applicant has a history of trauma, anxiety or depression this should be considered by their medical practitioner when completing this form.

Other Critical Information

- 8 and 12 hour roster (generally) – 8hrs shifts: 6am-2pm, 2pm-10pm and 10pm-6am; 12hrs shifts: 7am to 7pm, or 7pm to 7am (over 7 days).
- Management of young offenders includes regular face to face interaction.
- Immediate response to various contingency calls, including critical incidents and emergencies.
- The physical demands required for a Youth Worker are required to meet the challenging and demanding circumstances of most emergency activities.
- Youth Workers must therefore be able to rapidly respond to any incident within the detention environment and to be able to physically attend to various and potentially challenging circumstances.
- Challenging circumstances may not be encountered daily; however the Youth Workers should prepare for these situations by maintaining a certain level of agility, strength and overall fitness combined with high skill levels gained from continual training.
- Youth Workers work in an environment that is continually exposed to potential risk of injury and is reliant on skills, alertness and fitness in order to reduce those risks. In response to these demands, a Youth Worker requires:
 - an above average aerobic fitness
 - good upper and lower body strength
 - good range of motion of all joints
 - good balance responses
 - an above average shoulder and torso stability and core strength
- Safety regulations and public expectations dictate that a Youth Worker must be able to respond from the farthest part of the detention centre to the other, within a reasonable time frame, and to perform approved and trained techniques that may be required to diffuse the situation.
- This response distance could potentially be 350-500m including stairs
-

Department of Justice and Attorney General

Youth Worker, Youth Detention Medical Assessment

Instructions

1. This questionnaire will be used to assist in assessing your medical fitness in connection with your application for employment.
2. Answer all questions by ticking "Yes" or "No" and complete the "Explanatory Notes" section for any "Yes" box ticked. If there is insufficient space, attach a separate sheet.
3. Failing to supply full information or answering incorrectly may affect your employment.

Personal Details

Surname: _____ Given Names(s): _____

Drivers Licence or other photo id number: _____

Date of Birth: _____

Address: _____

Phone number: _____ Mobile number: _____

Email address: _____ @ _____

Our primary form of written contact with you will be by email. If there are any issues with your email address please let us know as soon as possible

Occupational History

Dates	Past Employer	Duties

If you have never been employed, please indicate 'none'

Sports/Recreation

From – To	Gentle, low, medium, or high intensity	e.g. times/week

If you do not perform any physical activity, please indicate 'none'

Musculoskeletal

If Yes, please
comment below

Do you currently have, or have you ever had:

- | | | |
|--|------------------------------|-----------------------------|
| 11. Any injuries to your spine, including your neck and back? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Any pain, injury or condition affecting your upper limbs including shoulders, elbows, wrist and hands? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Any pain, injury or condition affecting your lower limbs including hips, knees, ankles or feet? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Any other muscular, tendon, ligament or skeletal problem(s) not covered above? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Been advised to wear special footwear or orthotics? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Been advised to wear special footwear or orthotics? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Do you have any physical disabilities? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Explanatory notes

*Please quote the question number when completing details on any "yes" answers above.
Include approximate dates, condition, treatment and when the condition resolved.*

Respiratory

If Yes, please
comment below

Do you currently have, or have you ever had:

18. Any breathing difficulties, asthma, emphysema, bronchitis or other respiratory condition? Yes No

19. Any sleep problems or disorders such as sleep apnoea? Yes No

Explanatory notes

Please quote the question number when completing details on any "yes" answers above.
Include approximate dates, condition, treatment and when the condition resolved.

Psychological

If Yes, please
comment below

Do you currently have, or have you ever had:

20. Any mood disorder (suspected or diagnosed) such as depression? Yes No

21. Any anxiety disorder (suspected or diagnosed) such as obsessive compulsive disorder, PTSD, panic attacks or disorder? Yes No

22. Any psychotic illness (suspected or diagnosed) e.g. hallucinations, delusions, schizophrenia? Yes No

23. Any substance abuse disorder or addictive conditions e.g. alcohol/drug dependence/gambling/recreational drug use? Yes No

24. Any attention deficit disorder/attention deficit hyperactivity disorder (suspected or diagnosed)? Yes No

25. Any learning disorders? Yes No

26. Have you ever attempted suicide or self harm? Yes No

27. Have you ever used any antidepressant, anti-anxiety or other psychiatric medication? Yes No

28. Have you ever consulted a psychologist, psychiatrist, counsellor or other mental health professional? Yes No

Explanatory notes

Please quote the question number when completing details on any "yes" answers above.
Include approximate dates, condition, treatment and when the condition resolved.

Kessler Psychological Distress Scale (K10)

For all questions, please fill in the appropriate circle. Fill in the circles like this: ●
Please do not tick or cross the circles.

In the past 4 weeks	None of the time	A little of the time	Some of the time	Most of the time	All of the time
	①	②	③	④	⑤
1. About how often did you feel tired out for no good reason?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. About how often did you feel nervous?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. About how often did you feel so nervous that nothing could calm you down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. About how often did you feel hopeless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. About how often did you feel restless or fidgety?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. About how often did you feel so restless you could not sit still?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. About how often did you feel depressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. About how often did you feel that everything was an effort?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. About how often did you feel so sad that nothing could cheer you up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. About how often did you feel worthless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Today's date: / /					Total Score:

Explanatory Notes

What is the K10 and how is it scored?

The K10 is widely recommended as a simple measure of psychological distress and as a measure of outcomes following treatment for common mental health disorders. The K10 is in the public domain and is promoted on the Clinical Research Unit for Anxiety and Depression website (www.crufad.org) as a self report measure to identify need for treatment.

The K10 uses a five value response option for each question – all of the time, most of the time, some of the time, a little of the time and none of the time which can be scored from five through to one.







Alcohol Screen (AUDIT)

For all questions, please fill in the appropriate circle. Fill in the circles like this: ●

	①	②	③	④	Score	
1. How often do you have a drink containing alcohol?	Never <input type="radio"/>	Monthly or less <input type="radio"/>	2-4 times a month <input type="radio"/>	2-3 times a week <input type="radio"/>	4 or more times a week <input type="radio"/>	
2. How many standard drinks do you have on a typical day when you are drinking?	1 or 2 <input type="radio"/>	3 or 4 <input type="radio"/>	5 or 6 <input type="radio"/>	7 to 9 <input type="radio"/>	10 or more <input type="radio"/>	
3. How often do you have six or more standard drinks on one occasion?	Never <input type="radio"/>	Less than monthly <input type="radio"/>	Monthly <input type="radio"/>	Weekly <input type="radio"/>	Daily or almost daily <input type="radio"/>	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
9. Have you or someone else been injured because of your drinking?	Never <input type="radio"/>		Yes, but not in the last year <input type="radio"/>		Yes, during the last year <input type="radio"/>	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	<input type="radio"/>		<input type="radio"/>		<input type="radio"/>	
TOTAL						
Sum q						4,5,6

Supplementary Questions

Do you think you presently have a problem with drinking?	No <input type="radio"/>	Probably not <input type="radio"/>	Unsure <input type="radio"/>	Possibly <input type="radio"/>	Definitely <input type="radio"/>
In the next 3 months, how difficult would you find it to cut down or stop drinking?	Very easy <input type="radio"/>	Fairly easy <input type="radio"/>	Neither difficult nor easy <input type="radio"/>	Fairly difficult <input type="radio"/>	Very difficult <input type="radio"/>

Light Beer 425ml 2.9% Alcohol	Full Strength Beer 285ml 4.9% Alcohol	Wine 100ml 12% Alcohol	Fortified Wine 60ml 20% Alcohol	Spirits 30ml 40% Alcohol	Full Strength Can or Stubbie 375ml 4.9% Alcohol
					

The guide above contains examples of **one standard drink**.

A full strength can or stubbie contains **one and a half standard drinks**.

Neurological

If Yes, please
comment below

Have you ever had:

- | | | |
|--|------------------------------|-----------------------------|
| 29. Epilepsy/seizures/fits? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 30. Blackouts, fainting or loss of consciousness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 31. Any dizziness, vertigo or problems with balance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 32. Migraine or other frequent headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Explanatory notes

Please quote the question number when completing details on any "yes" answers above.
Include approximate dates, condition, treatment and when the condition resolved.

Cardiovascular

If Yes, please
comment below

Do you currently have, or have you ever had:

- | | | |
|--|------------------------------|-----------------------------|
| 33. Palpitations or irregular heartbeats? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 34. Chest pain on exertion or angina? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 35. Any other heart disease e.g. heart attack? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 36. High blood pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 37. Family history of heart disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Explanatory notes

Please quote the question number when completing details on any "yes" answers above.
Include approximate dates, condition, treatment and when the condition resolved.

Endocrine

If Yes, please
comment below

Have you ever been told you have:

- | | | |
|-------------------------------|------------------------------|-----------------------------|
| 38. Diabetes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 39. Thyroid disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 40. Other endocrine disorder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Explanatory notes

Please quote the question number when completing details on any "yes" answers above.
Include approximate dates, condition, treatment and when the condition resolved.

Declaration

I declare that the above has been answered truthfully and without deception.

I understand that disciplinary action, including termination of my employment with the Department of Justice and Attorney General, may be taken if I have failed to answer any of the above questions truthfully or have omitted any details when answering each question.

I have read the job demands and have no concerns regarding my capacity to meet the physical requirements without risk to any pre-existing condition.

Signature: _____ Date _____/_____/_____

Print Name: _____

Consent

1. I authorise appropriate officers of the Department of Justice and Attorney General, or any other party acting at their request, to gain access, obtain or share any information concerning my health and medical history for the purposes of determining my medical suitability for position applied for.
 Yes No
2. I consent to the use of my medical information for research purposes. Your information will be de-identified and you will remain anonymous for any research that is undertaken. This will have no effect on decisions regarding your suitability for the role you have applied for.
 Yes No

Please ensure that both questions 1 and 2 have been answered.

Signature: _____ Date _____/_____/_____

Print Name: _____

Physical Examination

Height (m):	Weight (kg):	BMI (kg/m ²):		
Waist circumference(cm):		Hip measurement(cm):		
Urinalysis	<input type="checkbox"/> Protein	<input type="checkbox"/> Blood	<input type="checkbox"/> Glucose	<input type="checkbox"/> All negative

Visual Acuity

Uncorrected	Distance vision	R 6/	L 6/	Both 6/
Corrected	Distance vision	R 6/	L 6/	Both 6/
Uncorrected	Near vision	R N	L N	Both N
Corrected	Near vision	R N	L N	Both N
Colour vision: Ishihara 24 or 38 plate		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	No. of errors:

Notes:

Hearing

Ear canals and tympanic membranes	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Whisper test passed:	Left <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Right <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

Notes:

Cardiovascular System

Cardiovascular System	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Blood Pressure:			Pulse rate:
If BP > 140/90 please repeat Blood Pressure:			Pulse rate:
Heart sounds	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Heart rate	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Chest auscultation	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Abdominal examination	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:

Musculoskeletal Examination

Spine (including) neck and back

Appearance	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Curvature	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Symmetry	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Forward flexion	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Straight Leg Raise	Left leg: °	Right leg: °	
Overall examination	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:

Shoulders

Appearance	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Range of movement	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Power	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Overall examination	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:

Wrist and hands

Appearance	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Range of movement	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Power	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Overall examination	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:

Hips

Appearance	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Range of movement	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Power	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Overall examination	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:

Knees

Appearance	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Range of movement	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Power	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Duck walk	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Signs of degenerative disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Notes:
Overall examination	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:

Ankles/feet

Appearance	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Range of movement	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Able to walk on heels/toes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Notes:
Overall examination	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:

Additional notes

Nervous System

Reflexes

Biceps	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Triceps	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Brachioradialis	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Knee	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Ankle	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Babinski	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Mental state	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Tremors	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Balance and Co-ordination	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Romberg's	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:
Squatting (repetitions x 5)	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Notes:

Additional notes

Department of Justice and Attorney General

Youth Worker, Youth Detention Fitness for Employment

I certify that I have examined (name) _____ Photo ID Number: _____

I have reviewed the critical job demands and other critical information with the applicant.

I have considered the Critical Job Demands for the position of Youth Worker, Youth Detention.

It is my opinion that the applicant has no significant:

Medical history	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychiatric/psychological history	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cardiac history	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vision abnormalities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Colour deficiency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing abnormalities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Examination findings	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Is this applicant able to perform the inherent requirements of the position as Youth Worker? Yes No

Comments

Do they have any condition that significantly increase their risk of work related disease or injury? Yes No

Comments

Do they require any restrictions (please specify)? Yes No

Comments

Based on this information, I have determined that the applicant is:

- Low risk
- Medium Risk
- High Risk
- I am unable to make a determination.
(please provide details including what further information may be required)

Signature: _____ Date _____ / _____ / _____

Print Name: _____ Stamp: _____