

# Firefighter Applicant Instruction Sheet

## Insulin Pump

Any applicant on an insulin pump for treatment of diabetes must supply all the following medical information on the day of their pre-placement medical assessment.

### Instructions for applicant:

1. Bring the information from the checklist to your pre-placement medical assessment.
2. Please **do not** include the medical information requested with your application form as it contains personal and confidential medical information.
3. Documentation must be completed **within the last 6 months** from your pre-placement medical assessment date. *(For example, if the medical assessment is scheduled for January 6, 2016, all your required documents must be dated July 6, 2015 or later.)*

### Checklist:

**Note:** Please download and print the Essential Job Tasks and Annex E and provide to the physician that will be completing this form for you.

- Firefighter Applicant: Insulin Pump Medical Form** (attached form). This form must be completed by your primary health care physician(s). The physician must have been actively involved in the management of your diabetes (e.g. family physician and/or endocrinologist). This form must also be completed **within the last 6 months** from the pre-placement medical assessment date.

## Firefighter Applicant Insulin Pump Medical Form

Any applicant on Insulin Pump for treatment of diabetes must bring in this completed form on the day of their pre-placement medical assessment. This form must be completed **within the last 6 months** from the applicant's pre-placement medical assessment date.

**This form must be completed by your primary health care physician(s), who has been actively involved in the management of your diabetes (e.g. family physician and/or endocrinologist).**

### Applicant Information

Last Name	First Name	Initial	Date of Birth (YYYY/MM/DD)
Address	City	Province	Postal Code

### Physician Information

Name of Physician	Specialty	Date of Examination (YYYY/MM/DD)
Address of Physician		Phone Number

1. Current insulin regimen:

Start date on current regimen: \_\_\_\_\_

Insulin pump brand and model: \_\_\_\_\_

Pump settings:

Start Time					
Basal Rate					

Start Time					
Basal Rate					

Usual Bolus doses:

Breakfast	
Lunch	
Supper	
Other	

Correction Factor: \_\_\_\_\_

2. The applicant has completed the following education in the use of a continuous insulin infusion pump (indicate name of course and year of completion):

3. Has the applicant demonstrated a proper understanding in the use of the insulin pump?

Yes – please explain.

No – please explain.

4. Indicate start date for use of pump: \_\_\_\_\_

5. History of insulin site infections:

6. The applicant has had more than one pump site infection that caused him/her to miss work or usual daily activities in the preceding six months.

Yes – please explain.

No

7. History of pump cessation and pump malfunction:

8. The individual routinely carries appropriate supplies to compensate for pump malfunction, including syringes and insulin vials or insulin pens.

Yes

No – please explain.

9. Frequency of infusion set changes:

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Physician Signature