



<b>Survival Systems USA, Inc.</b>		Program: <b>COMM</b>	Effective Date: <b>12/02/09</b>	Prepared by: <b>TLW</b>
Document Code: <b>SS-COMM-SOH</b>	Revision #: <b>005</b>	Original Issue Date: <b>02/09</b>	Revision Date: <b>12/01/09</b>	Approved by: <b>RGM</b>
Reference: <b>Application, Consent, Release and Statement of Health</b>				Page <b>1 of 2</b>

**CONFIDENTIAL WHEN COMPLETED**

The requirement that you complete this questionnaire is Survival System USA Inc.'s effort to protect you from medical mishap during your forthcoming training. By its nature this form cannot be exclusive and important medical information may have been missed. Please ensure that any other medical information concerning your health, of which you have any knowledge, is described below.

FIRST \_\_\_\_\_ MI \_\_\_\_\_ LAST \_\_\_\_\_ SUFFIX \_\_\_\_\_  
 HOME ADDRESS \_\_\_\_\_ CITIZENSHIP \_\_\_\_\_  
 \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 \_\_\_\_\_ DD/MMM/YYYY  
 \_\_\_\_\_ ZIP \_\_\_\_\_ AGE \_\_\_\_\_ Male/Female \_\_\_\_\_  
 HOME PHONE ( ) \_\_\_\_\_ WORK ( ) \_\_\_\_\_ LAST FOUR OF SSN \_\_\_\_\_  
 E-MAIL: \_\_\_\_\_  
 FIXED and/or ROTARY (Circle one or both) WHAT AIRFRAME(S) DO YOU FLY? \_\_\_\_\_  
 HAVE YOU EVER ATTENDED SSUSA TRAINING? Yes or No If so, WHEN? \_\_\_\_\_ WHERE? \_\_\_\_\_  
 HAVE YOU EVER ATTENDED ANY OTHER DUNKER TRAINING OR SWET/EBS TRAINING? Yes or No  
 If so, WHEN? \_\_\_\_\_ WHERE? \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
 EMPLOYER'S ADDRESS \_\_\_\_\_  
 \_\_\_\_\_  
 SUPERVISOR'S NAME \_\_\_\_\_ TITLE \_\_\_\_\_  
 PHONE NUMBER ( ) \_\_\_\_\_  
 HOW DID YOU HEAR ABOUT SURVIVAL SYSTEMS? \_\_\_\_\_

**PERSON TO BE NOTIFIED IN CASE OF ILLNESS OR INJURY**  
 NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 PHONE NUMBER HOME ( ) \_\_\_\_\_ WORK ( ) \_\_\_\_\_

<b>FOR THE FOLLOWING: PLEASE BE SURE TO INCLUDE PARTICULARS (I.E. DATE, DURATION, RESULTS OF TESTS, NAMES OF DOCTORS, ETC).</b>			
	YES	NO	COMMENTS
Have you ever had any illness or disease or consulted a doctor for:			
Brain or nervous system? (such as epilepsy, fainting spells, nervous disorder)			
Respiratory system? (such as bronchitis, pleurisy, asthma, hay fever)			
Heart or blood vessels? (such as heart murmur, coronary, angina, increased blood pressure, varicose veins, rheumatic fever, or stroke)			
Digestive organs? (such as stomach ulcer, jaundice, gall bladder, liver disease, hemorrhoids, hernia, or intestinal disorder)			
Urinary or generative organs? (such as kidney stone, kidney disease, enlargement, sugar or albumin in urine)			
Bones or joints? (such as dislocated joins or "trick joints" (shoulder/knee), rheumatism, arthritis, gout, slipped disc, or other back problems, any amputation or bodily deformity)			
Ears or eyes? (such as ruptured eardrum, history of ear infections, or barotrauma )			
Endocrine system? (such as diabetes, allergies, thyroid problems)			
Have you ever had cancer or other malignant disease?			
Are you currently taking prescription medication? If yes, please indicate name, strength, and taken per month.			
Have you taken any medication (prescription or otherwise) today? If yes please indicate name, strength and approximate time taken?			
Have you, during the past five years, been attended by a physician other than stated above, had other than routine X-rays, electrocardiograms, or other special medical tests performed, including the Elisa or HTLV-111 tests?			



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<b>CONTINUE ON REVERSE SIDE:</b>			
	<b>YES</b>	<b>NO</b>	<b>COMMENTS</b>
Have you smoked tobacco in the past year? If yes, indicate if you are still smoking, type smoked (cigarettes, cigars, pipe, etc.) and how much per week.			
Have you suffered from any of the following:			
Chest pain			
Palpitations			
Shortness of breath			
Weak spells			
Loss of consciousness			
Severe allergic reactions			
Major surgery			
Pneumothorax (spontaneous or other)			
Are you suffering from any illness or condition not mentioned above?			
Do you have any psychological problems, i.e. claustrophobia (fear of enclosed spaces), acrophobia (fear of heights), hydrophobia (fear of water)?			
Have you ever tested positive for a Bloodborne Pathogen Disease like (HIV, AIDS, HEPATITIS, etc...)?			
Do you currently have positive test results for a Bloodborne Pathogen Disease like (HIV, AIDS, HEPTITIS, etc...)?			
Have you ever been SCUBA diving? If yes, indicate year's certified and average number of dives per year?			
<b>Females only:</b>			
Have you had any disorder of the reproductive organs or breasts?			
Are you now pregnant?			

**\*\* For students, all jewelry is specifically prohibited during any practical exercise session with the exception of wedding bands – Survival Systems strongly discourages all students from wearing wedding bands during any practical exercise session.**

I understand that I will be subjected to rigorous physical activity which may include swimming, underwater disorientation, exposure to cold water, climbing scramble nets, and wearing breathing apparatus. I hereby state that I am in proper physical condition to participate in and be subjected to such physical activities and I am aware that participation could, in some circumstances, result in physical injury. I further state that I have no medical condition that would preclude my participation in these activities.

I release Survival Systems USA Inc., its officers, directors, agents, and employees and their executors, administrators, successors and assigns from any claims, demands, damages, actions or causes of action arising out of or as consequence of any loss, injury, death or damage to my person, or property, incurred while attending, participating in or resulting from participating in any and all courses at Survival Systems USA Inc., notwithstanding any such loss, injury, death or damage may have risen by reason of negligence of Survival Systems USA Inc., its officers, directors, agents or employees.

I consent to any emergency medical treatment which might be necessary and undertake to immediately advise Survival Systems USA Inc. if there is any change in my medical condition during the course of my training, or if I should become aware of any condition which would or might preclude my participation in the course of activities and training.

I understand, declare that the answers to the above questions are full, complete and true, and are correctly recorded, and are in continuance of and form a part of the application for training with Survival Systems USA Inc.

DATE: \_\_\_\_\_ TRAINING SITE: \_\_\_\_\_

SIGNATURE OF APPLICANT: \_\_\_\_\_

(A photographic copy of this shall be as valid as the original)

**FOR OFFICE USE ONLY:**

**SITE EMT:**  
ACCEPTED \_\_\_\_\_  
**NOT Accepted** \_\_\_\_\_  
DATE \_\_\_\_\_

**SITE MANAGER:**  
ACCEPTED \_\_\_\_\_  
**NOT Accepted** \_\_\_\_\_  
DATE \_\_\_\_\_

**EMT NOTES:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_