WorkSafe Tasmania
PO Box 56, Rosny Park, TAS 7018
Phone: (in Tasmania) 1300 366 322; (outside Tasmania) 03 6166 4600
Email: wst.licensing@justice.tas.gov.au |Website: www.worksafe.tas.gov.au

Questionnaire/Medical Examination for a Dangerous Goods Licence

Dangerous Goods (Road and Rail Transport) Act 2010 - Dangerous Goods (Road and Rail Transport) Regulations 2021

MEDICAL PRACTITIONER TO RETAIN

Given Names

Surname

Residential Address

Suburb

Postcode

Date of Birth

Mobile Phone

Email

GENERAL GUIDELINES/CHECKLIST

Completion of Forms DG1 & DG2 is required to obtain a Dangerous Goods Driver Licence. Questions in this Questionnaire/Medical Examination form are from AustRoads "Assessing Fitness to Drive" (AFD)

- ☐ Complete questionnaire section before attending Medical Examination
- ☐ Take Form DG1 & DG2 to your Medical Practitioner who will complete Medical Examination
- ☐ Medical Practitioner to retain Form (DG2)
- ☐ Form DG2 not to be completed anymore than 6 months prior to application
- ☐ Form DG1 to be completed and given to Service Tasmania

Personal information we collect from you will be used by the Delegate of the Competent Authority for dangerous goods licensing purposes and may be used for other purposes permitted by the *Dangerous Goods (Road & Rail Transport) Act 2010* and associated laws. Failure to provide this information may result in your application being denied or records not being properly maintained. Your personal information may be disclosed to contractors and agents of WorkSafe Tasmania, law enforcement agencies, courts and other public sector bodies or organisations authorised to collect it. This information will be managed in accordance with the *Personal Information Protection Act 2004* and may be accessed by you on request to this Department. You may be charged a fee for this service.

Expires 30 June 2027

Applicant to Complete

Please answer the questions by ticking the correct box. If you are not sure, leave blank and ask your doctor what it means.
The doctor will ask you additional questions during the examination

	Yes	No
1. Are you currently being treated by a doctor for any illness or injury?	☐	☐
2. Are you receiving any medical treatment or taking any medication (either prescribed or otherwise)	☐	☐
3. Have you ever had, or been told by a doctor that you had any of the following?	☐	☐
3.1. High blood pressure	☐	☐
3.2. Heart disease	☐	☐
3.3. Chest pain, angina	☐	☐
3.4. Any condition requiring heart surgery	☐	☐
3.5. Palpitations/irregular heart beat	☐	☐
3.6. Abnormal shortness of breath	☐	☐
3.7. Head injury, spinal injury	☐	☐
3.8. Seizures, fits, convulsions, epilepsy	☐	☐
3.9. Blackouts, fainting	☐	☐
3.10. Stroke	☐	☐
3.11. Dizziness, vertigo, problems with balance	☐	☐
3.12. Double vision, difficulty seeing	☐	☐
3.13. Colour blindness	☐	☐
3.14. Kidney disease	☐	☐
3.15. Diabetes	☐	☐
3.16. Neck, back or limb disorders	☐	☐
3.17. Hearing loss or deafness or had an ear operation or use a hearing aid?	☐	☐
3.18. Do you have difficulty hearing people on the telephone (including use of hearing aid if worn)	☐	☐
3.19. Have you ever had, or been told by a doctor that you had a psychiatric illness, or nervous disorder?	☐	☐
3.20. Have you ever had any other serious injury, illness, operation, or been in hospital for any reason.	☐	☐
4.1. Have you ever had, or been told by a doctor that you had a sleep disorder, sleep apnoea or narcolepsy?	☐	☐
4.2. Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep?	☐	☐

4.3.How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you. Use the following scale to chose the most appropriate number for each situation. It is important that you put a number (0-3) in each of the 8 boxes.

0 = Would never doze off
1 = Slight chance of dozing off
2 = Moderate chance of dozing off
3 = High chance of dozing off

Situation	Chance of Dozing (0-3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or meeting)	
As a passenger in a car for and hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	

Continued

5. Please tick the answer that is correct for you:

5.1 How often do you have a drink containing alcohol?

Never ☐ Monthly or less ☐ 2 or 4 times a month ☐ 2 or 3 times a month ☐ 4 or more times a week ☐

5.2 How many drinks containing alcohol do you have on a typical day when you are drinking?

1 to 2 ☐ 3 to 4 ☐ 5 to 6 ☐ 7 to 9 ☐ 10 or more ☐

5.3 How often do you have six or more drinks on one occasion?

Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily/almost daily ☐

5.4 How often during the last year have you found that you were not able to stop drinking once you have started?

Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily/almost daily ☐

5.5 How often during the last year have you failed to do what was normally expected of you because of drinking?

Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily/almost daily ☐

5.6 How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session?

Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily/almost daily ☐

5.7 How often during the last year have you had a feeling of guilt or remorse after drinking?

Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily/almost daily ☐

5.8 Has you or someone else been injured as a result of your drinking?

No ☐ Yes, but not in the last year ☐ Yes, during the last year ☐

5.9 Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

No ☐ Yes, but not in the last year ☐ Yes, during the last year ☐

6. Do you use illicit drugs? Yes ☐ No ☐

7. Do you use any drugs or medication not prescribed for you by your doctor? Yes ☐ No ☐

8. Have you been in a vehicle crash since your last licence examination? Yes ☐ No ☐

If you answered Yes to Questions 6, 7 or 8 please give details:

Declaration by Applicant

Name

I declare that to the best of my knowledge the above information supplied by me is true and correct.

Signature of Applicant

Date

IMPORTANT: For privacy reasons, the completed Applicant Questionnaire must not be returned to WorkSafe Tasmania. Medical information relevant to driver licensing should be included on the Medical Certificate and on the Medical Condition Notification Form (for assessments made in the course of applicant's treatment).

Medical Practitioner to Complete

Please retain on patient file. For privacy reasons **DO NOT** supply to WorkSafe Tasmania. Medical information and findings relevant to the person's fitness to drive should be recorded on the medical fitness to drive assessment form.

1. Cardiovascular System:

1.1 Blood pressure (Repeat if necessary)

Systolic		mm Hg	Systolic	mm Hg
Diastolic		mm Hg	Diastolic	mm Hg

	Normal	Abnormal
1.2 Pulse Rate		
1.3 Heart Sounds		
1.4 Peripheral Pulses		
2 Chest/Lungs		
3. Abdomen (Liver)		
4. Neurological/Locomoter		
4.1 Cervical Spine Rotation		
4.2 Back Movement		
4.3 Upper Limbs -- Appearance		
Upper Limbs -- Joint Movements		
4.4 Lower Limbs -- Appearance		
Lower Limbs -- Joint Movements		
4.5 Reflexes		
4.6 Romberg's sign (A pass requires the ability to maintain balance while standing with shoes off, feet together side by side, eyes closed and arms side by side for thirty seconds)		

5. Vision

5.1 Visual Acuity

Uncorrected Right	6/	Uncorrected Left	6/
Corrected Right	6/	Corrected Left	6/

Are glasses or contact lenses worn? ☐ Yes ☐ No

The AFD states a person is NOT fit to hold an unconditional licence if their uncorrected visual acuity is worse than 6/9 in the better eye or worse than 6/18 in either eye. The full criteria for a conditional licence is available in the medical standard, which includes that a conditional licence may be considered subject to periodic review if this requirement is met with the use of corrective lenses.

	Normal	Abnormal
5.2 Visual Fields (confrontation to each eye)		
6. Hearing		
7. Urinalysis		
7.1 Protein		
7.2 Glucose		

8. Neurophyschological Assessment

Where clinically indicated apply the Mini Mental State Questionnaire or General Health Questionnaire or equivalent.

Score:

Relevant Medical findings

Health professional comments on any relevant findings detected in the questionnaire or examination.