

Statement of Understanding

By signing below, I agree to participate in an in-service training program of at least twenty-four (24) hours annually and maintain a minimum of 33% of all meetings per year.

I understand that my membership may be terminated for reasons of physical or mental health, failing to maintain attendance requirements to meetings, and failing to maintain required training hours.

I hereby state that the information I have provided is correct and true to the best of my knowledge. I authorize the use of this information in my assessment for qualifications to the applied specialized team.

Applicant Signature

Date

Applicant Name Printed

Burke County Agency Representative

Date

Agency Representative Name Printed

Burke County Emergency Services Medical Form

The information on this form is for official departmental use only and will not be released without the written permission of the applicant or employee.

Instructions: This form is to be completed by applicant prior to physical examination and presented to the attending physician at the time of his/her examination. All questions must be answered completely and accurately.

Have you ever or do you know of any of the following: For questions answered yes, provide explanation on rear of page.

1.	Head injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	31.	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Sensitivity to dust	<input type="checkbox"/> Yes <input type="checkbox"/> No	32.	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Back problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	33.	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Other allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	34.	Nervous System Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Fractures to bones/joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	35.	Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Frequent colds	<input type="checkbox"/> Yes <input type="checkbox"/> No	36.	Gall Bladder problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	37.	TB/lung disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Lameness	<input type="checkbox"/> Yes <input type="checkbox"/> No	38.	Kidney problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Tumor, growth, cyst	<input type="checkbox"/> Yes <input type="checkbox"/> No	39.	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	40.	Hemorrhoids	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Childhood diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No	41.	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Knee problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	42.	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Feet problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	43.	Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	44.	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Eye injury, surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	45.	Poison Oak/Ivey	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	46.	Speech impediments	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	Ever worn glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No	47.	Claustrophobia	<input type="checkbox"/> Yes <input type="checkbox"/> No
18.	Ever worn contacts	<input type="checkbox"/> Yes <input type="checkbox"/> No			
19.	Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No			
20.	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No			
21.	Low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No			
22.	Hearing problems	<input type="checkbox"/> Yes <input type="checkbox"/> No			
23.	Varicose veins	<input type="checkbox"/> Yes <input type="checkbox"/> No			
24.	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No			
25.	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No			
26.	Mental disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No			
27.	Drug abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No			
28.	Alcohol abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No			
29.	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No			
30.	Fainting/dizzy	<input type="checkbox"/> Yes <input type="checkbox"/> No			

48. Have you ever had or been advised to have an operation. If so, please describe.

49. Have you ever been a patient in a mental hospital (voluntary or involuntary)? If so please describe.

50. Have you ever had any other injury, disease, or physical condition not named (other than childhood illnesses and minor injuries). If so, please describe.

51. Have you had an injury in the last five (5) years that caused you to lose time from work? If so, please explain.

52. Have you ever been deferred from military services for medical, emotional, or other reasons? If so, please explain.

53. Have you ever received or applied for pension, compensation, or retirement for disability or injury. If so, please explain.

54. Are you presently under the care of a Physician for any reason? If so, please explain.

55. Are you currently taking medications or have you taken medications in the last twelve (12) months. If so, please list the medications other than over the counter medications.

56. Do you or have you ever had any physical or emotional limitations. If so, please explain.

57. Please have the examining Physician document his account for any questions answered yes. Please indicate by the number of the question beside his/her explanation. Be as specific as possible.

Penalty

Any falsification, withholding, or failure to answer all questions completely and accurately may cause forfeiture of all rights to membership or employment.

I hereby certify there are no misrepresentations or falsifications in the foregoing statements. Answers to all questions, all answers and statements are true and correct to the best of my Knowledge.

Applicant/Employee Signature

Date

Instructions: To be completed by a licensed Physician or his/her designee.

Name: _____ DOB: _____
Last First MI. Month Day Year

SS#: _____ - _____ - _____ Age: _____ Height: _____ Weight: _____

Chest Girth (Expiration): _____ Abdomen Girth (Expiration): _____

Visual Activity (If applicant/employee wears glasses or contacts, test with and without)

Without Glasses/Contacts: R20/____ L20/____ B20/____

With Glasses/Contacts: R20/____ L20/____ B20/____

Depth Perception: _____ Color Perception: _____ Pupils Equal: _____ Pupils Reactive: _____

Eye Grounds: _____ Form Fields of Vision (temporal): Right _____ Left _____

Each eye on line: _____

Any abnormalities: _____

Hearing (Whispered conversation at 15 feet considered normal)

Right: 15/____ Left: _____ Hearing Aids used? Yes No

Drum perforation or drainage? Yes No

Note any abnormalities: _____

Head: _____
(note any defect, disease, or injury involving eyes, ears, nose, mouth, throat)

Lungs: _____
(rate, depth, equal)

Cardiovascular System	Blood Pressure	Pulse Rate	Pulse Rhythm
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At rest	_____	_____	_____
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After step test	_____	_____	_____
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Two minutes after step test	_____	_____	_____
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Circulation to extremities: _____
(note any abnormalities)

Nervous System: _____
(describe any abnormal reflexes)

Abdomen: Masses _____ Tenderness _____ Hernia _____

Rectal: Fissures _____ Fistule _____ Hemorrhoids _____

Genitourinary System: _____
(note any abnormalities)

Musculoskeletal System (Bending, stooping, squatting, and by head, leg, and finger motions)

Spine: Mobility _____ Symmetry _____ Posture _____

Upper Extremities: Limited functions _____ Missing parts _____

Lower Extremities: Limited functions _____ Missing parts _____

Skin: _____
(scars, varicosities, disease, abnormalities)

Date of most recent Tetanus Vaccine: _____

Any Lab work attached to this physical: _____

Are there any conditions, physical, mental, or emotional, which in your opinion suggest further test or evaluation? _____

Summary: Comments / Instructions

I have examined _____ and have found him/her to be physically capable of performing the duties of the position applied for in the emergency services field.

Physician Signature: _____ Date: _____

Physician Name and Address (Printed or Typed) _____

