DATE_____

Last Name: _____ First Name: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

Telephone #: (Home) _____ (Cell) _____

Email Address: _____

Date of Birth_____ Social Security#_____

Emergency Contact _____

Address (if different)_____

Contact Phone #_____Home___ Cell____

Date Joined Department: _____ Date Terminated: _____ Reason: _____

Previous Fire or EMS Experience: (Indicate Certifications and any command positions)

_____

_____

_____

_____

_____

_____

ATTACH COPY OF DRIVERS LICENSE

Medical Statement of Personnel

This form is designed to provide the individual in charge of all personnel a complete history of physical status as of the date indicated without the need for expensive physical examinations. It is recommended that the form be completed on an annual basis by all drivers of emergency vehicles as well as other employees. If any of the questions are answered "YES," be sure the answer is fully explained below.

Questions:

Name:_____

Address: _____

City & State: _____ Zip: _____

Occupation: _____

1. Birth Date: Month _____ Day: _____ Year: _____

	YES	NO
2. **Eyesight**:		
a. Have you lost use of either eye? _____R _____L	a. ☐	b. ☐
b. Is peripheral (side) vision restricted?	a. ☐	b. ☐
c. Are you color blind?	a. ☐	b. ☐
d. Do you have, or have you ever had, cataracts?	a. ☐	b. ☐
e. Are actual deficiencies corrected by glasses or contact lenses?	a. ☐	b. ☐
f. Date of last eye examination?	a. ☐	b. ☐
3. **Hearing:**		
a. Do you have difficulty hearing normal conversation level?	a. ☐	b. ☐
b. Do you use a hearing aid?	a. ☐	b. ☐
4. **Diabetes:**		
a. Have you ever been treated for diabetes?	a. ☐	b. ☐
b. List current medication and dosage, if any, and method of administration: _____		
c. Date of latest blood sugar test:	a. ☐	b. ☐
5. **Heart:**		
a. Have you ever been treated for heart disease?	a. ☐	b. ☐
b. Describe condition: _____ _____		
c. Describe current medication and dosage: _____ _____		
d. Do you have a pacemaker?	a. ☐	b. ☐
e. Date of last treatment or check-up? _____		
6. **Epilepsy:**		
a. Have you ever been treated for epilepsy?	a. ☐	b. ☐
b. If yes, when was your last seizure?_____		
c. List current medications and dosage: _____ _____		

7. **Blood Pressure:**
   a. Have you ever been treated for high blood pressure? ……..... a. ☐ b. ☐
   b. If yes, when were you treated? _____
   c. What was your last reading? _____
   d. List current medications and dosage: _____
   _____

8. **Limbs:**
   a. Have you lost an arm or leg? …… a. ☐ b. ☐
   b. Have you lost the use of an arm or leg? ……a. ☐ b. ☐
   c. Does vehicle have special controls? …..……a. ☐ b. ☐
   d. If yes, to any of the above, please describe: _____
   _____

9. **Miscellaneous:**
   a. Have you ever had, or been treated for convulsions? ……a. ☐ b. ☐
   b. If yes, give date of last treatment and describe current medication and dosage: _____
   c. Have you ever had any fainting spells? …… a. ☐ b. ☐
   d. If yes, give date of last treatment and describe current medication and dosage: _____
   e. Have you ever had, or been treated for loss of equilibrium? ……a. ☐ b. ☐
   f. If yes, give date of last treatment and describe current medication and dosage: _____
   g. Have you ever been treated for alcohol or drug abuse? ……a. ☐ b. ☐
   h. If yes, give date of last treatment and describe current medication and dosage: _____
   i. Have you ever been treated for mental illness? …… a. ☐ b. ☐
   j. If yes, give date of last treatment and describe current medication and dosage: _____

10. What is the date of your last physical examination? _____
11. Are there any restrictions posted on your vehicle operator's license? Please list:
    _____
12. Are you under the care of a physician for any condition not mentioned above which may affect your ability to operate a motor vehicle? ……..a. ☐ b. ☐
    If yes, please explain: _____
    _____
13. When and for what purpose did you last consult a doctor? _____
    _____
14. Full name, address, and telephone number of your personal physician:
    Name: _____
    Address: _____
    City & State: _____ Zip: _____
    Telephone #: _____

The answers to the above are complete, accurate, and true to the best of my knowledge.

_____ _____
Signature of Person Named Above **Date**

Authorization for Release

I hereby authorize any licensed physician, medical practitioner, hospital or medically related facility, insurance company, the Medical Information Bureau or any other organization, institution, or person that has any records or knowledge of me or my health, to give St. James Fire Department any such information. Photographic copy, Xerox copy or similar reproduction of this authorization shall be as valid as the original.

_____ _____
Signature of Person Named Above **Date**