Initial-Hire Medical Standards Medical Examination Form

Commonwealth of Massachusetts Human Resources Division

This form is to be used for all medical examinations performed pursuant to the Medical and Physical Fitness Standards Regulations for Public Safety Personnel. Communities not subject to these regulations may also use this examination form.

Completed by Municipality (type or print in ink)

Name of Examinee (Last, First, Middle) ____

Municipality:____________________________ Social Security #_____________________ Date of Birth__________________

Appointing Authority Email:___________________________________Dept. Chief Email: __________________________________

Position: ☐Police Officer ☐Firefighter

Exam: ☐Initial Exam ☐Other Exam (Please explain) _________________________

Privacy Notice

The collection of the information on this form is authorized under regulations filed with the Secretary of State of the Commonwealth of Massachusetts. This information will be used to determine the fitness-for-duty of public safety personnel. The information may be disclosed to the Municipal Keeper of the Records; an appropriate government agency for law enforcement purposes; where relevant in a legal or administrative proceeding to which the Commonwealth or a Commonwealth municipality is a party or has interest; to a government agency upon its request when relevant to its decision concerning employment or other benefits; to an expert consultant or other person under contract with the Commonwealth of Massachusetts to fulfill an official agency function including audits of services provided under these Medical Standards; to an investigator, administrative judge, or complaints examiner appointed for the investigation of a formal complaint of employment discrimination; to officials with responsibility for administering workers' compensation, disability retirement, and other benefit entitlements; to an examinee's private treating physician; and to medical personnel retained by the Commonwealth of Massachusetts to provide medical services in connection with an employee's health or physical condition related to employment. Completion of this form is voluntary. If this information is not completed, the examination may be considered incomplete. ***Knowingly providing false or incomplete answers may result in the rescission of a conditional job offer or dismissal if discovered at a later time.***

Consent and Certification (Completed by Examinee)

I hereby authorize collection and use of the information on this form for the purposes stated in the above Privacy Notice. I have read and understand the provisions of the Privacy Notice included in this form. I certify that all the information given by me in connection with this examination will be correct and complete to the best of my knowledge and belief.

I also understand that if I fail an initial medical examination, I may undergo a reexamination within 16 weeks of the date of the failure of the initial examination. If I fail to pass the reexamination, my appointment can be rescinded. (M.G.L. Chapter 31, Section 61A.)

Signature of Examinee ____ **Date** ____________________

It is mandatory that a **signed copy** of this cover page, and a copy of the Medical Verification Section (page 8) be returned by e-mail to PAT@mass.gov.

Name of Examinee____ Social Security Number _____________________

A. Medical History (completed by examinee before examination)

INSTRUCTIONS: Please answer all questions accurately and completely. If you do not understand any question, you should request clarification from the examining physician. The information provided regarding your medical history and health habits will be used to make a medical assessment of whether you can safely and effectively perform the essential functions of a public safety position. Detailed medical information will be treated confidentially. It is essential that you answer all questions accurately and completely. Please note that a history of a health problem will be carefully evaluated and will not necessarily disqualify you from employment.

Do you now have or have you ever had any of the following: (Check **Y**es or **N**o)

	Yes	No		Yes	No
1. Fracture of skull, jaw or facial bones			40. Stroke, Aneurysm, or Bleeding in head		
2. Concussion or other injury to head			41. Multiple sclerosis or muscular dystrophy		
3. Thoracic outlet syndrome			42. Myesthenia gravis or ALS		
4. Fracture of neck, vertebrae or spine			43. Epilepsy or seizures		
5. Recurrent back or neck pain			44. Dementia or memory loss		
6. Degenerated or herniated disc			45. Migraines or other severe headaches		
7. Back injury or other abnormality			46. Paralysis or muscle weakness		
8. Back, spine or neck surgery			47. Other neurological disorders		
9. Osteoporosis			48. Eczema or other skin disease		
10. Arthritis or joint injury or disease			49. Skin grafts		
11. Amputation involving hand or foot			50. Bleeding disorder/anticoagulation		
12. Carpal tunnel syndrome			51. Sickle cell disease or trait		
13. Other hand or wrist problems			52. Blood clots or thrombosis		
14. Dislocation of any joint			53. High or low blood cell counts		
15. Injury or abnormality of arms or legs			54. Enlarged or ruptured spleen		
16. Need for corrective lenses			55. Diabetes or high blood sugar		
17. Deficiency of color vision			56. Thyroid or other endocrine disorder		
18. Disease of the eyes or sinuses			57. Cancer, malignancy or tumor		
19. Loss of hearing			58. Mental or emotional disorder		
20. Exposure to loud noise			59. Mental health treatment of any type		
21. Disease of the ear or vertigo			60. Lupus, scleroderma, dermatomyositis		
22. Deformity of mouth or jaw			61. Heat stroke, frostbite or burns		
23. Speech impediment or disorder			62. AIDS, HIV infection or hepatitis		
24. Tuberculosis			63. Any history of alcohol or drug abuse		
25. Pneumothorax or collapsed lung			64. Current use of any prescribed drug		
26. Bronchitis, asthma or other lung disease			65. Allergies or chemical sensitivities		
27. Abnormal electrocardiogram (EKG)			66. Occupational (work) injuries		
28. Heart disease or cardiac abnormality			67. Disability or compensation claim		
29. Irregular heart rhythm			68. Asbestos or toxic chemical exposures		
30. Angina/chest pain/shortness of breath			69. Required light or restricted duty		
31. Hypertension/high blood pressure			70. Military rejection or medical discharge		
32. Organ transplant			71. Medical treatment in past 12 months		

33. Liver, pancreas or gall bladder disease			72. CAT Scan, MRI or other special tests		
34. Ulcer or bowel disease			73. Smoked cigarettes or tobacco products		
35. Intestinal bleeding			74. Are you pregnant?		
36. Hernia of any type			75. Any sleep disorder		
37. Kidney or bladder disease			76. Heavy snoring		
38. Abnormal balance or coordination			77. Shortness of breath with light activities		
39. Fainting, blackouts or dizzy spells			78. Other health conditions		

Please explain "yes" answers by referencing item number.

Provide (in the section to the right of each #) pertinent information relative to diagnosis and treatment for each "yes" response. Include dates for injuries, illnesses and follow up treatments. Please use the back of this page if necessary.

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Name of Examinee_______________________ **Social Security Number** _______________

B. Medical Examination

INSTRUCTIONS: After reviewing the Medical History provided in Section E, conduct a comprehensive examination of all systems necessary to determine the examinee's fitness under the applicable public safety position Medical Standards. The examination should include, but not be limited to, the areas listed below. If the examiner finds that the examinee has physical examination findings relevant to a determination of whether the examinee will likely be able to safely and effectively perform the essential functions of the position being considered, the examiner is responsible for documenting all such conditions.

Height______ **Weight**_________ **Blood Pressure**______/____ **Temperature**______

Pulse ______

Vision Testing	Without Corrective Lenses	With Corrective Lenses
Distant	Rt. 20/___ Lt. 20/_____ Both 20/____	Rt. 20/___ Lt. 20/_____ Both 20/____
Near	Rt. 20/___ Lt. 20/_____ Both 20/____	Rt. 20/___ Lt. 20/_____ Both 20/____

Visual Fields (degrees)

Right: Temporal________ **Nasal** ___________

Left: Temporal________ **Nasal** ___________

Color Vision: ☐**Passed** ☐**Failed**

EXAMINATION	Normal	Abnormal (Identify by number and explain if abnormal)
1. Skin	_______	_______________________________
2. Head, face and scalp	_______	_______________________________
3. Ears, tympanic membranes	_______	_______________________________
4. Eyes, pupils, fundi, motion	_______	_______________________________
5. Nose, sinuses, olfaction	_______	_______________________________
6. Mouth, throat, speech	_______	_______________________________
7. Neck, thyroid	_______	_______________________________
8. Heart	_______	_______________________________
9. Varicosities, bruits, pulses	_______	_______________________________
10. Chest, lungs	_______	_______________________________
11. Breasts (if indicated)	_______	_______________________________
12. Abdomen, hernia	_______	_______________________________
13. Rectum (if indicated)	_______	_______________________________
14. Endocrine	_______	_______________________________
15. Spinal mobility, alignment	_______	_______________________________

16. Upper extremities, hands _______ ____

17. Lower extremities, feet _______ ____

18. Muscle strength, tone _______ ____

19. Gait, Rhomberg _______ ____

20. Balance, coordination _______ ____

21. Reflexes _______ ____

22. Cranial Nerves _______ ____

23. Mental Status _______ ____

24. General Appearance _______ ____

☐MD ☐DO ☐NP ☐PAC (Check one)

Print name of examining health care provider ____

Signature of examining health care provider ____ Date _________________

Name of Examinee____ **Social Security Number** ______________________

C. Laboratory and Diagnostic Tests

INSTRUCTIONS: Three diagnostic tests are **required** under the Medical Standards. Although not specifically required under the Medical Standards, additional tests may be performed. Some tests **may be required** by the appointing authority or approved by the appointing authority to further evaluate conditions detected on the medical history form and/or during the physical examination. For each test performed indicate below whether the results were **normal** or **abnormal** and document any abnormal results in Section H. **Copies of all laboratory reports should be attached to this form as part of the permanent record**.

REQUIRED TESTS:

A. Spirometry* ☐Normal ☐Abnormal

B. Audiogram* ☐Passed ☐Failed

C. Purified Protein Derivative (PPD) Test or interferon-gamma release assay (IGRA) for tuberculosis[6]

☐Negative ☐Positive

OTHER TESTS:

D. D. Urine Dipstick* ☐Normal ☐Abnormal ______ Sp. Gravity______ Protein______ Sugar_____

E. E. CBC* ☐Normal ☐Abnormal

F. F. Chemistry panel* ☐Normal ☐Abnormal

G. Urine drug screen* ☐Negative ☐Positive

H. Electrocardiogram* ☐Normal ☐Abnormal

I. Chest X-Ray* ☐Normal ☐Abnormal

J. Hepatitis B Immunization* Dates of Immunizations: #1____________________#2____________#3 _______

K. Tetanus Immunization* Dates of Immunizations: _______________________________________

L. Other* ____

[6] *Applicants with newly found positive tuberculosis test results must be evaluated in consultation with a tuberculosis specialist regarding need for treatment and any restriction on participation in activities involving close contact with others.*

**The candidate should be informed of abnormal results in these evaluations in writing so he/she may consult with his/her primary care physician.*

D. Additional Notes

INSTRUCTIONS: Use this section to summarize any additional medical history information, abnormal physical examination findings, abnormal diagnostic or laboratory test results, and any other relevant information obtained during your evaluation. Please note that sufficient information must be documented so that your decision-making process is clear to any reviewer in the event that the examinee appeals an adverse fitness determination.

In the event that an examinee does not pass the examination, please document in the Medical Verification Section whether **each** disqualifying condition represents a Category A or Category B condition, as defined in the Medical Standards. If Category B, please explain below why you determined that the examinee's condition precluded his or her safe and effective performance of one or more of the essential functions of the public safety position. Additional pages (i.e. transcription notes) may be attached to this form. Also, note in section F(Category B medical alert form) of this form any medical conditions that, though not immediately disqualifying, may either need to be assessed through functional performance or that have a medically reasonable chance of progression to a point where they may adversely affect safe and effective performance of the relevant essential job functions.

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☐MD ☐DO ☐NP ☐PAC (Check one)

Print name of examining health care provider ____

Signature of examining health care provider ____ **Date** _________________

E. Medical Verification Section

INSTRUCTIONS: Review the medical history, physical examination documentation, diagnostic test results, and laboratory reports in relation to the applicable public safety position Medical Standards and make a determination (regarding) whether the examinee meets all requirements of the Medical Standards. Conditions classified under Category A in the Medical Standards preclude an examinee from work in the public safety position. Conditions listed under Category B in the Medical Standards require careful individual consideration and may require further evaluation to determine whether the condition would preclude this individual from safely and effectively performing the essential functions of the public safety position. If there is uncertainty regarding an examinee's health status or functional abilities which could be resolved with additional information, the examinee should be offered the opportunity to provide medical records, reports from medical specialists, or any other relevant information in order to determine passed or failed status. In this case, the examinee should be advised by the examining physician as to what information is needed for follow up. He or she should be provided with a reasonable, but specific amount of time during which to provide the reports to the examining physician, who will thereafter advise the municipality of the status of the examinee.

If an examinee fails an initial medical examination, he or she is eligible to undergo a reexamination within 16 weeks of the date of the failure of the initial examination. If the examinee opts for a reexamination, he or she must arrange it with the municipal authority.

NOTE: In cases where the medical examination has been performed by a nurse practitioner or physician's assistant, a doctor of medicine or osteopathy must sign this Medical Verification Section.

When all necessary information has been received and reviewed, complete this Medical Verification Section and distribute per instructions below. Medical examination records are the property of the municipal authority. They must be kept accessible for the duration of the examining physician's contract for use in the event of an audit, appeal or disability proceeding. If the contract terminates or expires, the physician will be instructed to transfer these records to his or her successor. The physician, however, may retain copies of his or her own examination reports and selected materials.

Name of Physician____

Address of Physician________________________**Telephone:** ______________________________

Date of Medical Examination:____________________________**for Fire Department** ☐ **Police Department**☐

Physician Email: ____

PHYSICIAN'S CERTIFICATION OF FITNESS

I have reviewed the medical examination for the following examinee using the Human Resources Division's Medical Standards Program for Public Safety Personnel:

☐ Initial Exam
☐ Other Exam (Please explain) ____

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Name of Examinee: ________________________________ Social Security #: ________________

Home Address:____

Home Telephone:____

Physician must certify whether candidate *passed* or *failed* the medical exam:

☐ **I hereby certify that the above named examinee *passed* the medical examination.**

Or

☐ **I hereby certify that the above named examinee *failed* the medical examination.**

Section Failed __________________ Category A ☐ Category B ☐

Section Failed __________________ Category A ☐ Category B ☐

Section Failed __________________ Category A ☐ Category B ☐

Section Failed __________________ Category A ☐ Category B ☐

Section Failed __________________ Category A ☐ Category B ☐

Section Failed __________________ Category A ☐ Category B ☐

PHYSICIAN'S NOTICE OF EXAMINEE'S FAILURE TO PROVIDE COMPLETE & ACCURATE MEDICAL HISTORY (See Privacy Notice on Page 1 of this form and please provide comments below and attach documents if necessary.)

☐MD ☐DO ☐NP ☐PAC (Check one)

Print name of examining health care provider ___________________________________

Signature of examining health care provider ______________________________ **Date** ______________

The Medical Verification Section must be returned to the Appointing Authority. The Appointing Authority will forward the Medical Verification Section, along with a signed copy of page one of this Medical Examination Form to the Human Resources Division (HRD). These Sections may be e-mailed to PAT@mass.gov

F. Category B Medical Alert Form

INSTRUCTIONS: The purpose of this form is to ensure that a passing examinee with one or more Category B conditions which do not result in a failure, but do represent a potential future risk to the examinee in terms of his/her future health and ability to safely perform the duties of a police officer/fire fighter based on the existing medical understanding of the progression of the condition, is notified of the condition(s) and the recommendation to monitor the condition(s) on a regular basis. In addition, given the inherent risk to the individual and others while serving in a public safety position, the same information will be provided to the appointing authority. It is the responsibility of the examining physician to determine when it is appropriate to use this form, to ensure that the form is completed properly, and to inform the examinee in person and the appointing authority by phone or mail. *[NOTE: Upon request, the examinee can be provided with a copy of this form.]*

Completed by the Physician **LISTING OF CATEGORY B CONDITION(S)** (such as diabetes, disease of the eye, etc.) **THAT REPRESENT A POTENTIAL RISK TO THE EXAMINEE:** Be specific regarding each condition and the current status as of the examination date listed above.

Completed by the Examinee Immediately after Presentation by the Examining Physician

ACKNOWLEDGEMENT OF RECEIPT OF SUPPLEMENTAL MEDICAL INFORMATION:

The examining physician presented and explained the medical condition(s) listed above. By signing this form, I acknowledge that:

- I asked questions of the examining physician to ensure I understood the medical condition(s) at least at a basic level that would enable me to discuss the issues with my personal physician.
- I understand that the condition(s) does not disqualify me from being hired as a police officer/fire fighter.
- I understand that it is the recommendation of the examining physician that I discuss the condition(s) with my personal physician and develop an ongoing plan for monitoring my condition since it is likely to progress at some point in the future and it is impossible to predict how quickly or slowly that change may take place.
- I understand that given the inherent risks to myself, other members of the department, and the public while performing the duties associated with a police officer/fire fighter, the same information will be shared with the appointing authority.
- I acknowledge and give my permission for the physician to release my personal medical information specific to the condition(s) listed above ONLY to the appointing authority.

My Name (Printed):____Today's Date: ____________________

My Signature: ____

Completed by the Physician

PERFORMANCE OF RESPONSIBILITIES:

I acknowledge informing the examinee of the potential risks listed above on the date listed on this form.

I also informed the appointing authority of the existing conditions for this individual and recommendation for ongoing monitoring of the individual through: (check one)

☐ a formal letter (attached) ☐an e-mail (printed and attached)

Signature of Physician: ________________________________

Date of Examination:____

Name of Examinee (Printed): ____

Name of Physician (Printed): ____