COMMONWEALTH OF MASSACHUSETTS
HUMAN RESOURCES DIVISION

MEDICAL EXAMINATION FORM
INITIAL-HIRE MEDICAL STANDARDS

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.

A. Completed by Municipality (type or print in ink)

Name of Examinee (Last, First, Middle)_____

Municipality_____ Social Security #_____ Date of Birth_____

Position: Police Officer_____ Firefighter_____

☐ Initial Exam ☐ Other Exam (Please explain) _____

B. 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.***

C. 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 6) be returned by e-mail to PAT.Coordinator@state.ma.us or mailed to the Human Resources Division (HRD), Civil Service Unit, Room 301, at One Ashburton Place, Boston, MA 02108.

I. 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 efficiently 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'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) _____

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** _____

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.)

_____

_____

Physician Signature: _____ **Date:** _____ **License #** _____

Print Physician Name: _____ **MD DO (circle one)**

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.Coordinator@state.ma.us, or mailed to the Commonwealth of Massachusetts, Human Resources Division, Civil Service Unit, One Ashburton Place, Room 301, Boston, MA 02108.