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 for Public Safety Personnel.

		Completed by Mun	nicipality (type or print in	ink)
Name of Can	didate (Last, First, Midd	le)		
Municipality	:	Last 4 digit	ts Social Security #	Date of Birth
Appointing A	authority Email:		Dept. Chief Emai	il:
Position:	Police Officer	Firefighter		
Exam:	Initial Exam	Re- Exam	(Please explain) _	
Privacy Noti	ice			
enforcemer municipalit employmer to fulfill an administrat discriminat entitlement Massachuse employmer incomplete	at purposes; where relevally is a party or has intent or other benefits; to an official agency function live judge, or complaint ion; to officials with respect to an candidate's prietts to provide medical att. Completion of this for	nt in a legal or administra- rest; to a government ag- expert consultant or other a including audits of servi- ats examiner appointed consibility for administerial ivate treating physician; a services in connection rem is voluntary. If this in- false or incomplete answer	tive proceeding to which the gency upon its request whe reperson under contract with ices provided under these M for the investigation of ang workers' compensation, and to medical personnel with an employee's hea afformation is not completed	e Commonwealth or a Commonwealth or relevant to its decision concerning in the Commonwealth of Massachusetts Medical Standards; to an investigator, a formal complaint of employment disability retirement, and other benefit I retained by the Commonwealth of alth or physical condition related to d, the examination may be considered accission of a conditional job offer or
Consent and	Certification (Comple	ted by Candidate)		
have read a	nd understand the provis	sions of the Privacy Notic		ated in the above Privacy Notice. I ertify that all the information given by nowledge and belief.
	of the initial examination			nation within 16 weeks of the date of twill be rescinded. (M.G.L. Chapter
Signature	of Candidate			Date
				ation Section be returned by e-mail

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to PAT@mass.gov.

Name of Candidate	Last 4 digits Social Security #

A. Medical History (completed by candidate 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 Yes or No)

	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. Myasthenia 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		

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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	1		
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	s		
39. Fainting, blackouts or dizzy spells			78. Other health conditions			
"yes" response. Include dates for injuries, ill # # # # # #	nesses a	and fo			neces	ssary.
#						
#						

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all systems necessary examination should in	to determine the clude, but not be relevant to a dete	candidate's e limited to, termination of	fitness under the app the areas listed below f whether the candida	licable public sat . If the examiner te will likely be a	fety position I finds that the able to safely a	nensive examination of Medical Standards. The candidate has physical and effectively perform all such conditions.
Height	Weight		Blood Pressure	/	Temperatu	re
Pulse						
Vision Testi	ng V	/ithout Cor	rective Lenses	٧	Vith Correct	tive 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						
Left: Temporal	Nasal					
Color Vision: Passe	d □Failed					
EXAMINATION	No	rmal	Abnormal (Identify	by number and	l explain if al	onormal)
1. Skin						
2. Head, face and sc	alp <u>[</u>					
3. Ears, tympanic mo	embranes	<u> </u>				
4. Eyes, pupils, fund	li, motion					
5. Nose, sinuses, olfa	action					
6. Mouth, throat, spe	eech					
7. Neck, thyroid						
8. Heart						
9. Varicosities, bruit	ts, pulses					
10. Chest, lungs						
11. Breasts (if indicate	ed)	<u> </u>				
12. Abdomen, hernia						
13. Rectum (if indicat	ted)	<u> </u>				
14. Endocrine		<u> </u>				
15. Spinal mobility, a	lignment	_] [

Name of Candidate______ Last 4 digits of Social Security# _____

B. Physical Examination

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Signature of examining health care provider		Date
Print name of examining health care provider		
MDDO	(Check one)	
24. General Appearance		
23. Mental Status		
22. Cranial Nerves		
21. Reflexes		
20. Balance, coordination		
19. Gait, Rhomberg		
18. Muscle strength, tone		
17. Lower extremities, feet		
16. Upper extremities, hands		

Name of Candidate	Last 4 digits Social Security #
C. Laboratory and Diagnostic Tests	
INSTRUCTIONS: Three diagnostic tests are required under the under the Medical Standards, additional tests may be performed. or approved by the appointing authority to further evaluate condithe physical examination. For each test performed indicate below document any abnormal results in Section H. Copies of all labor the permanent record.	Some tests may be required by the appointing authority itions detected on the medical history form and/or during whether the results were normal or abnormal and
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 AbnormalSp. 0	GravityProteinSugar
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 Candidate 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 <u>others.</u>

^{*}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 candidate appeals an adverse fitness determination.

In the event that an candidate does not pass the examination, please document in the Medica each disqualifying condition represents a Category A or Category B condition, as define Category B, please explain below why you determined that the candidate's condition preclude performance of one or more of the essential functions of the public safety position. Additional may be attached to this form. Also, note in section F(Category B medical alert form) of the that, though not immediately disqualifying, may either need to be assessed through function medically reasonable chance of progression to a point where they may adversely affect safe a relevant essential job functions.	d in the Medical Standards. If ded his or her safe and effective l pages (i.e. transcription notes) is form any medical conditions nal performance or that have a
Print name of examining physician	
Signature of examining physician	

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 candidate meets all requirements of the Medical Standards. Conditions classified under Category A in the Medical Standards preclude an candidate 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 candidate's health status or functional abilities which could be resolved with additional information, the candidate 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 candidate 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 candidate.

If an candidate 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 candidate 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.

Address of Physician	Telephone:
Date of Medical Examination:	for Fire Department Police Department
Physician Email:	
PHYS	ICIAN'S CERTIFICATION OF FITNESS
I have reviewed the medical examination Standards Program for Public Safety Pers	for the following candidate using the Human Resources Division's Medical onnel:
Initial Exam Re- Exam (Please expl	lain)
Name of Candidate:	_Last 4 digits SSN #:
Physician must certify whether candidate	
	ed candidate <u>passed</u> the medical examination.
<u>Or</u>	
I hereby certify that the above name	ed candidate <u>failed</u> 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
	E'S FAILURE TO PROVIDE COMPLETE & ACCURATE MEDICAL HISTOM and please provide comments below and attach documents if necessary.)
MD_DO	
Print name of examining physician	
Signature of examining physician	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

INSTRUCTIONS: The purpose of this form is to ensure that a passing candidate with one or more Category B conditions which do not result in a failure, but do represent a potential future risk to the candidate 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 candidate in person and the appointing authority by phone or mail. [NOTE: Upon request, the candidate can be provided with a copy of this form.]

Completed by the Candidate 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:	
PERFORMANCE OF RESPONSIBILITIE	Completed by the Physician S:	
	attached) an e-mail (printed and attached)	