EMT

Medical Examination Questionnaire

INSTRUCTIONS TO THE EXAMINING PHYSICIAN: The person being examined is an applicant for the position of EMT in the state of Arizona. EMT's are required to perform a variety of strenuous and difficult job functions. The purpose of this examination is to determine if the applicant is able to safely perform these essential job functions. Applicants may be required to attend an EMT course where both physical and mental stress is encountered. Please use the "Medical History Form" provided by the applicant in conjunction with the medical examination as a basis for completing this report.

PART I. APPLICANT'S INFORMATION (Please type or print)

1. NAME (First- Middle-Last): ______________________ 2. BIRTH DATE (Month-Day-Year): ________

3. Social Security Number: ______________ 4. Weight (without coat or shoes): ____ 5. Height (without shoes): ____

6. Sex: Male: ________ Female: ________ 7. Hiring Agency: ______________________

PART II. VISION AND HEARING

8. VISUAL ACUITY

DISTANCE

Uncorrected: R20/_____ L20/_____ B20/_____

Corrected: R20/_____ L20/_____ B20/_____

NEAR VISION

Uncorrected: R20/_____ L20/_____ B20/_____

Corrected: R20/_____ L20/_____ B20/_____

9. HORIZONTAL FIELD OF VISION

Right: ______ Left: ______ Both: ______

Check if Present:

Scatoma: __________

Quadrantonopia (large blind spot): ________

10. COLOR PERCEPTION

(NOTE ANY DEFICIENCIES)

Red: ______ Green: ______

Yellow: ______ Color Plates: ______

11. CORRECTION

None: ______ Spectacles: ______

Hard Contact Lenses: __________

Soft Contact Lenses: __________

Required if uncorrected vision is 20/80 or more.

12. HEARING (Audiometer must be used):

	500HZ	1000HZ	2000HZ	3000HZ
dbL	______	______	______	______
dbR	______	______	______	______

Hearing aid used? ______ Note any abnormalities in Comments - Section VII

PART III. CONTAGIOUS DISEASES

13. Does the applicant have contagious hepatitis? YES _____ NO _____

14. Does the applicant have contagious tuberculosis? YES ____ NO _____

PART IV. CONDITIONS

15. Based upon your examination and review of the applicant's Medical History Questionnaire, please check any of the listed conditions that apply:

Condition		Condition		Condition		Condition	
Angina pectoris		Diabetes, insulin, dependent or ketosis-prone		Paralysis		Substance abuse	
Asthma				Pilonidal cyst		Valvular heart disease (uncorrected)	
Cancer - metastatic or leukemia		Fixation of major joint		Prosthetic device, (e.g. limbs, hearing aid, colostomy)			
Cardiac arrhythmias or murmurs		Herniated lumbar disc		Recurrent dislocation of major joint		Wasting disease, chronic, (e.g. multiple sclerosis, myasthenia gravis, amyotrophic lateral sclerosis)	
Cerebral vascular accident		Hypertension, uncontrolled		Schizophrenia, manic depressive, psychosis			
Chest pains of unknown origin		Inguinal hernia					
Chronic respiratory disease		Liver or renal dysfunction		Scoliosis greater than 15 degrees		Any other physical or mental condition that may interfere with the applicant's ability to effectively function as a peace officer on a continuing basis or may create a reasonable probability of substantial harm to the applicant or others.	
Contagious disease not covered in Part III		Migraine headache					
		Myocardial infarction history		Seizure disorders			
		Neurosis					

PART V. ADDITIONAL INFORMATION

16. MEDICAL CONDITIONS (From Sections III and IV):
Please describe, in layman's terms, the common characteristics of any condition(s) checked on the reverse side of this form.

17. SYMPTOMS:
Please describe the specific symptoms of the condition(s) checked on the reverse side.

18. EFFECTS OF SYMPTOMS:
Please indicate how the symptoms in #17 affect the applicant's ability to perform the duties of a Firefighter/EMT.

19. TREATMENT:
Please describe the type and duration of any treatment indicated.

20. PROGRESSIVE NATURE OF CONDITION(S):
Are any of the condition(s) stated in #16 progressive in nature? YES _____ NO ______

PART VI. CERTIFICATION: Important - Physician Please Read Carefully (Physician's Assistant certification not accepted)

21. I certify that I have examined the applicant whose name appears on the reverse of this form and that I am a licensed physician in the United States of America. I further certify that based upon the applicant's history (which I have reviewed) and my physical examination, the applicant:

a. Is capable of performing the duties of an EMT without accommodations.

b. Is capable of performing the duties of an EMT with the following accommodations (list in comments section below):

c. Has a condition which requires further evaluation by a specialist in the field of:

d. Is not capable of performing the duties of an EMT.

PHYSICIAN'S NAME AND ADDRESS (type or print):

PHYSICIAN'S SIGNATURE: **Date:**

Medical Occupational Specialist: ☐

PART VII. COMMENTS

PART VIII. MEDICAL INFORMATION RELEASE (To Be Completed By Applicant)

I hereby authorize the examining physician whose signature appears on this form to release all information concerning my medical condition and history to Arizona Western College. I also certify that I have provided the examining physician with full, complete and accurate medical history.

APPLICANT'S SIGNATURE: ____ **DATE:** ________________________