Annual Physical/Fitness for Duty Instructions

For Firefighters and Fire Lieutenants Only

You have been scheduled for an annual physical and/or fitness for duty assessment at the Occupational Health Clinic, 230 North Woodland Boulevard, Suite 250, Deland, Florida. This office is located at the corner of Woodland Boulevard and Wisconsin Avenue in the Bank of America Building on the second floor.

This packet includes the following five forms that must be filled out prior to your appointment:

1. Drug and Alcohol, Test Acknowledgement Form
2. Medical Screening History
3. Employment Physical/Fitness for Duty Authorization
4. Respiratory History and Spirometry
5. Social Security Number Disclosure Statement

Selected candidates must:

- Plan to arrive at least 15 minutes prior to scheduled appointment time;
- Bring a list of all medications you're currently taking; and,
- Bring your state-issued driver's license or other state-issued identification card; and

If FASTING IS REQUIRED: Please have nothing to eat for 8-12 hours prior to your physical. You may have water or black coffee and any medications that you are required to take.

LATE ARRIVALS: In consideration of others, if you arrive 15 minutes or later after your scheduled appointment time, you may be rescheduled for another time and/or day if we're unable to work you in among the other scheduled appointments.

NOTIFICATIONS: You and your Department/Division will be notified of results within three to five business days unless you are placed on a medical hold.

If you have any questions or need assistance downloading and/or completing these forms, please contact the Occupational Health Clinic section at (386) 736-5984.

(1) DRUG AND ALCOHOL TEST ACKNOWLEDGEMENT FORM

Firefighters and Fire Lieutenants Only

I understand that testing for the presence of chemical substances or metabolites (legal and illegal drugs) and/or alcohol is being conducted in accordance with federal and state laws and County policies.

Job Applicants: I understand that as a job applicant with the County of Volusia, that my refusal to submit to the above testing, or a confirmed positive test result, is considered cause for refusal to hire me.

Current Employees/Volunteers: I understand that my refusal to submit to drug and alcohol testing, or a confirmed positive test, may be considered a violation of federal regulations and/or County policies and will result in disciplinary action up to and including termination of employment or severance of my volunteer duties. Additionally, a confirmed positive drug or alcohol test may result in forfeiture of workers' compensation benefits and have other criminal, legal, and employment consequences. I understand that I may request the testing laboratory to send the original urine specimen to another certified laboratory for retesting for drugs within 72 hours of notification by the Medical Review Officer (MRO) and that the County may seek reimbursement for all or part of the cost of the split specimen retest. I further understand that if I receive a positive confirmed drug or alcohol test result, I may explain or contest the result to the County within five (5) working days after receiving written notification and I must inform the testing laboratory of any administrative or civil action brought pursuant to drug-free workplace testing procedures and have the right to consult the Medical Review Officer (MRO) for technical and confidential information regarding prescription and nonprescription medications.

I have read this form (or this form has been read to me at my request for a reasonable accommodation under the provisions of the American with Disabilities Act-ADA) and I fully understand its meaning and the consequences of a positive drug and alcohol test.

Department/Division: Public Protection/Fire Services

_____	_____	_____
Print Applicant/Employee Name	Signature	Date

☐ Post-Offer Employment Physical
☐ Fitness-for-Duty Physical
☐ Annual Physical

(2) MEDICAL HISTORY QUESTIONNAIRE

Have you ever been examined medically by Volusia County?
If so when?

Please Print

Name Last	*First*	*Middle*	*Soc. Sec. No.*	*Date of Birth*	*Age*	*Gender*
						Male Female

Home Address	*City & State*	*Zip Code*

Position	*Department*	*Examination Date*

NOTICE: The answers to these questions must be complete and true. Any false statement or omission of a material fact is sufficient cause for, and may result in consequences up to and including termination.

HISTORY: To be completed out by applicant/employee prior to day of examination and checked by nurse.

HAVE YOU EVER HAD, OR DO YOU NOW HAVE, ANY OF THE FOLLOWING DISEASES OR CONDITIONS?

Explain <u>YES</u> answers and sign your name in the Comment Section on page 3.

	YES	NO			YES	NO	
1			Head injury or concussion	25			Heart infection
2			Are your teeth in good repair	26			Prolapsed heart valve
3			Cancer of any type	27			Coronary Artery Disease
4			Diabetes	28			Clogged arteries
5			Liver disease	29			High blood pressure
6			Skin disease	30			High cholesterol
7			Allergic reaction of any kind	31			High triglycerides
8			Rupture or hernia	32			Phlebitis
9			Epilepsy or convulsions	33			Varicose veins
10			Are you restricted from driving	34			Ear nose or throat issues (not related to colds or flu)
11			Eye injury or disease	35			Blood clots
12			Mouth or gum disease	36			Poor circulation
13			Kidney or urinary tract disease or failure?	37			Bleeding disorder or anemia
14			Mental or emotional illness or conditions Head injury or concussion	38			Frequent nosebleeds
15			Have you ever contemplated suicide	39			Vomiting of blood
16			Ever had Hepatitis A, B, or C	40			Blood in urine
17			Ever diagnosed as obese	41			Blood in stool or black tarry stool
18			Have a regular exercise program	42			Stroke
19			Nervous breakdown	43			Ulcers
20			Disorder related to stress	44			Blood transfusion
21			Had abnormal lab results	45			Does your heart race or skip beats
22			Heart disease	46			Any other cardiovascular disease not mentioned in this section
23			Rheumatic fever	47			Had an EKG, Stress test, Echocardiogram, Heart Catheterization or other cardiovascular testing
24			Heart murmur	48			Ever refused treatment for cardiovascular problems

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	YES	NO	
49			Had a chest x-ray?
50			Had an abnormal chest x-ray?
51			Wheezing or trouble breathing at times
52			Pleurisy more than once before
53			Bronchitis more than three (3) times in one year
54			Pneumonia, more than once in your life
55			Tuberculosis (TB)
56			Exposure to someone with TB
57			Coughing up blood
58			Torn cartilage, knee, ankle, shoulder
59			Epileptic Seizures
60			Herniated or slipped disc
61			Fasciitis
62			Scoliosis or Lordosis
63			Pain or loss of feeling in legs, feet, or ankles
64			Chronic back pain
65			Carpal Tunnel (Right/left/both)
66			Disease of the spine or vertebra
67			Need to use cane, crutches, walker or other assistive devices
68			Recurrent stiffness or back pain
69			Recurrent pulled muscles, tendons or sprains
70			Ever treated for musculoskeletal problems or injury
71			Have or had a job requiring heavy lifting, standing, walking, sitting for long periods of time
72			Have or had any broken bones
73			Have or ever had any other musculoskeletal disorder, or disease
74			Ever refused treatment for any musculoskeletal injury, disorder or disease
75			Can you lift 1 to 10 pounds
76			Can you lift 10 to 20 pounds
77			Can you lift 25 to 50 pounds
78			Can you lift 50 to 100 pounds
79			Can you lift more than 100 pounds

	YES	NO	
80			Coughing up phlegm, sputum or mucus frequently
81			Chronic cough without producing mucus, etc.
82			Used oxygen at home or in the hospital
83			Other respiratory disease
84			Ever refused medical treatment for any lung disorder
85			Arthritis
86			Rheumatism
87			Bursitis
88			Tendonitis
89			Have a history of substance abuse or alcohol
90			Are you addicted to any drugs or alcohol
91			Have been treated for drug or alcohol addiction
92			Have you ever used tobacco products
93			Do you still use tobacco products
94			Have you used tobacco products in the last 12 months?
95			Do you smoke?
96			Are you being treated for any current medical condition (explain in comments)
97			Have you ever experienced a serious illness or injury (explain in comments)
98			Ever been hospitalized? (explain in comments)
99			Ever been injured on the job or experienced any job related illnesses (explain)
100			Have any mental or physical impairments originating from birth (flat feet, hearing loss, etc.)
101			Women: Are you pregnant
102			Take any prescription or non prescription medications or supplements (list in comments)
103			Ever received radiation treatment
104			Otherwise been exposed to radiation
105			Ever had any communicable diseases (such as measles, mumps, chicken pox) Explain in comments.
106			Ever been in an accident that caused loss of time from work (auto, boat, motorcycle, etc.)
107			Ever had a work related accident
108			Had the Hepatitis A vaccination (list dates)
109			Had the Hepatitis B vaccination (list dates)
110			Had a tetanus shot (list date of last)

COMMENT SECTION

(Reference corresponding question number next to each comment – use additional page if needed.)

I, the undersigned, do hereby certify that I have read and truthfully responded to each question on the Medical History Questionnaire (Pages 1 through 3) to the best of my ability and knowledge. The answers I have given to the questions are true and can be supported. I have no physical or mental impairments, except as stated. I understand that any intentional omission, dishonesty in disclosure, or falsification of answers written in this document may result in my termination of employment.

Print Name:_____Signature:_____Date:_____

Volusia County
FLORIDA

(3) EMPLOYMENT PHYSICAL/FITNESS FOR DUTY AUTHORIZATION FORM

I understand that continued employment with the County of Volusia is contingent upon passing an employment physical. Any protected health information gathered for this physical will remain under separate medical files in the Occupational Health Clinic.

I also understand that if I do not pass the physical, I cannot be employed by the County of Volusia or cannot return to duty. I also understand that by not signing this authorization, I cannot go back to work and may be subject to disciplinary action.

The Undersigned agrees as follows:

1. I consent for the Volusia County Occupational Health Clinic medical personnel to provide me with a complete physical examination, including, but not limited to, all items required on the standard county physical form and, if necessary, a stress test and tobacco usage test and therefore do hereby consent to said physical.

2. I authorize the release of the results stated as, “medically acceptable” or “medical unacceptable” only, as required to certify certain employees as employable.

3. I make the above agreements freely and voluntarily and with a full understanding of the physical examination.

4. By reading and initialing this, _____ (initials), I authorize the clinic personnel to release my medical records concerning my job duties to my employer. This authorization is required in order to meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

I, the undersigned, do hereby certify that to the best of my knowledge, the answers I have provided to the questions herein are true and that I have no physical defects except as stated. I understand that if I do not pass the physical and/or fitness for duty examination, I cannot return to duty. I also understand that any intentional omission or falsification of answers either verbally or in writing may result in termination of my employment.

Type of Physical (check one): _____ Annual _____ Fitness for Duty

_____	_____	_____
Print Employee Name	Signature	Date

Volusia County
FLORIDA

(4) RESPIRATORY HISTORY AND SPIROMETRY

Employee Name: _____ SSN: _____

Current Job or Position: _____

Have you ever had or currently have any of the fol1owing? (Check below if yes)

- ☐ Asthma
- ☐ Valley Fever
- ☐ Tuberculosis
- ☐ Other Lung Problem
- ☐ Food, Dust, or Animal Allergy
- ☐ Hay Fever, Sinusitis
- ☐ Chronic Bronchitis
- ☐ Surgery of Lungs, Heart, or Blood Vessels
- ☐ Emphysema
- ☐ Collapsed Lung
- ☐ Abnormal Chest X-Ray

	YES	NO	
1			Have you ever worked with asbestos or in any dusty environment such as a mine, stone quarry, foundry, farm, pottery, cotton, flax or hemp mill, or chemical plants? (Underline if Yes) Other:
2			Have you ever worked with x-ray or any radioactive materials, or had any physical condition due to exposure to radioactive materials?
3			Have you ever had or currently have any hobbies that expose you to wood or other dust, gases, or fumes such as paints, glues and solvent? What?
4			Do you cough on most days? If Yes, is it in morning only? or all day?
5			Do you cough up Phlegm, Sputum, or mucous?
6			Have you ever noted wheezing, whistling or tightness in your chest?
7			Have you ever coughed up blood?
8			Do you get short of breath when hurrying on level ground, walking up a slight hill or climbing stairs?
9			Are you using any medications for Lung or Heart Problems? What?
10			Have you ever smoked cigarettes? Average number per day ____ for ____ years. Last smoked on _____. If stopped, when?
11			Any breathing difficulties when wearing a mask?
12			Any anxiety or claustrophobia when wearing a mask?
13			When working, do you need to wear eyeglasses? or contact lens?
14			Do you wear dentures?
15			Can you lift 35 pounds to shoulder level?
16			Have you had respiratory infection within the past three weeks, i.e. severe cold, pneumonia, influenza, or bronchitis?
17			Have you smoked within the last hour?
18			Have you used an aerosolized bronchodilator in the past hour?
19			What kind of work have you done for the longest period? How many years?

Signature: _____ Date: _____

(5) SOCIAL SECURITY NUMBER DISCLOSURE STATEMENT

FINANCIAL AND ADMINISTRATIVE SERVICES

PERSONNEL DIVISION

This statement is being provided to you pursuant to Section 119.071 (5), Florida Statutes.

The Occupational Health Clinic collects your social security number and may disclose your social security number to a commercial entity for the following purposes, including but not limited to: drug testing administration, physical exams, medical records, blood work, worker's compensation administration, claims investigation and for any purpose allowed under law not limited by protection under state or federal privacy laws.

Social security numbers are also used as a unique numeric identifier and may be used for search purposes. The County of Volusia may disclose social security numbers to another agency or governmental entity if it is necessary for the receiving agency or governmental agency to perform its duties and responsibilities.

I have read and understand the social security number disclosure statement:

_____
Signature

_____
Printed Name

_____
Date

Personnel Division
Occupational Health Clinic
230 N. Woodland Blvd. Suite 250 - DeLand, Florida 32720
Tel: 386-736-5984 – Fax: 386-740-5214 (www.volusia.org)