Pre-employment Physical/Fitness for Duty
AUTHORIZATION FORM

I understand that I have been conditionally offered employment with the County of Volusia contingent upon passing a pre-employment physical. Any protected health information gathered for this physical will remain under separate medical files in the Risk Management office. **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.**

☐ **Pre-employment Physical**

I understand that by not signing this authorization, I cannot be considered for employment with the County of Volusia.

☐ **Annual Physical**

I understand that by not signing this authorization, I cannot go back to work and may be subject to disciplinary action.

☐ **Fitness for Duty Physical**

I understand that by not signing this authorization, I cannot go back to work and may be subject to disciplinary action.

____
Name (please print)

____
Signature

____
Date

Pre-Employment Physical Instructions

You have been scheduled for a pre-employment physical at the County of Volusia's Risk Management Office, 230 N. 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.

Selected Candidates must:

1. plan to ***arrive at least 15 minutes prior to scheduled appointment*** time. If candidate is unable to download the above-mentioned forms, he/she must contact Risk Management;
2. bring a list of all medications currently taking;
3. bring his/her **driver's license** or other state-issued identification card and ***original*** **social security card** or a recent receipt from the Social Security Office (with candidate's name and social security number on it). Call 1-800-772-1213 for the nearest Social Security Office location if you need to obtain a new card.

If FASTING is REQUIRED, *please have nothing to eat for 8-12 hours prior to your physical. Candidates may have water or black coffee and any medications that he/she is required to take.*

LATE ARRIVALS: In consideration of others, if a candidate arrive 15 minutes or later after his/her scheduled appointment time, he/she may be rescheduled for another time and/or day if we're unable to work him/her in among the other scheduled appointments. R*escheduling an appointment may delay the candidate's employment date with the County*

NOTIFICATIONS: Department/Divisions and candidates will be notified of results within three to five business days unless the candidate is placed on a medical hold.

Please direct all questions to Cindy Sakalo, Office Assistant III, in the Personnel's Risk Management section at (386) 736-5963.

PHYSICAL EXAMINATION - REQUEST AND CONSENT

The Undersigned agrees as follows:

1. I consent for the Volusia County Risk Management 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 Risk Management to release my medical records concerning my job duties to my employer. This authorization is required in order to meet HIPPA 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 any intentional omission or falsification of answers either verbally or in writing may result in termination of my employment.

____

Signed:

____

Date:

Volusia County Risk Management

DRUG, ALCOHOL & TOBACCO USAGE TESTING FORM

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

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. If currently employed by the County, I understand that my refusal to submit to drug, alcohol and/or tobacco 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 also 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 M.R.O. 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 written notification and that 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 for technical and confidential information regarding prescription and non-prescription medications.

I have read, 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 tobacco test, if applicable, or a positive drug or alcohol test.

______________________________ ______________________________

Applicant/Employee (please print) Signature & Date

Applicants or Volunteers under age 18 REQUIRE a parent or legal guardian's signature.

______________________________ ______________________________

Parent/Legal Guardian Name (print) Signature & Date

VOLUSIA COUNTY RISK MANAGEMENT

RESPIRATORY HISTORY AND SPIROMETRY

EMPLOYEE NAME: ______________________________ SSN: _______________________

1. Current job or position: _______________________________________

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

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

YES	NO		
		2.	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: _________________________________
		3.	Have you ever worked with x-ray or any radioactive materials, or had any physical condition due to exposure to radioactive materials?
		4.	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? _________
		5.	Do you cough on most days? If Yes, is it in morning only? ___ or all day? _____
		6.	Do you cough up Phlegm, Sputum, or mucous?
		7.	Have you ever noted wheezing, whistling or tightness in you chest?
		8.	Have you ever coughed up blood?
		9.	Do you get short of breath when hurrying on level ground, walking up a slight hill or climbing stairs?
		10.	Are you using any medications for Lung or Heart Problems? What? ___________
		11.	Have you ever smoked cigarettes? Average number per day __________ for _______ years. Last smoked on ______ If stopped, when _____________
		12.	Any breathing difficulties when wearing a mask?
		13.	Any anxiety or claustrophobia when wearing a mask?
		14.	When working, do you need to wear eyeglasses? __ or contact lens? ____
		15.	Do you wear dentures?
		16.	Can you lift 35 pounds to shoulder level?
		17.	Have you had respiratory infection within the past three weeks, i.e. severe cold, pneumonia, influenza, or bronchitis?
		18.	Have you smoked within the last hour?
		19.	Have you used an aerosolized bronchiodialator in the past hour?
		20.	What kind of work have you done for the longest period? ____________ How many years? _______

Date: ______________ Signature: ______________________________________

VOLUSIA COUNTY RISK MANAGEMENT
MEDICAL HISTORY SCREENING
(PLEASE PRINT)

Date:		
Appointment type: Pre-employment ☐ Annual ☐ Re-hire ☐		
Department:	Driver's License #:	
Position:	SS#:	
Name:	Phone #:	
Mailing Address:	Sex:	
	Date of Birth:	
Person to Notify in Case of Emergency (Relationship):	Address:	Phone #:
Family Physician	Address	Phone #:
Family History: Diabetes ☐ Stroke ☐ Heart Disease ☐ Cancer ☐ High Blood Pressure ☐		
The purpose of the following information is to aid the physician in evaluating your functional health status as it relates to the position for which you are applying.		
Do you have any physical limitations? Yes ☐ No ☐ Explain:		
Do you have any impairment of sight, hearing, or speech? Yes ☐ No ☐ Explain:		
Have you ever had a physical with Volusia County Government before? Yes ☐ (Year _____) No ☐		

PLEASE ANSWER EACH QUESTION

DO YOU HAVE OR EVER HAD THE FOLLOWING?	YES	NO	IF YES, GIVE DETAILS
Diabetes			
Hay Fever			
Stroke			
Cancer			
Liver Disease, Jaundice			
Skin Problems			
Rupture or Hernia			
Serious accident (sustaining multiple injuries)			
Have you ever been injured on the job or in the course of any current or previous employment?			
Are you receiving any disability income?			
Do you have or have you had mental or emotional illness?			
Have you ever attempted suicide?			
Have you ever had and/or have a history of substance abuse, eg: drug/alcohol?			
Have you been rejected or denied insurance, employment or acceptance in the Armed Forces?			

Name:		Date:	
	YES	NO	**IF YES, GIVE DETAILS**
Have you had convulsions or seizuresor take medication for above?			
Do you take medications or supplements? Please list:			
Have you used tobacco products in the last 12 Months?			
If smoker, how many packs per day & age started.			
Have you ever smoked?			
If yes, age started & age stopped.			
Do you have any allergies to medications or other substances?			
Do you have a regular exercise program?			
Do you now, or have you ever had ear, nose or throat trouble?			
Do you now or have you ever had an eye injury/eye disease?			
Have you been exposed in your past or present work to the following; excessive noise, fumes, chemicals, brick, stone or sand dust?			
Have you ever received radiation as a treatment?			
Have you been immunized against: Tetanus?			Date:
Hepatitis A and or B?			Date:
Are you under treatment for any medical problem?			
Women: Are you pregnant at this time?			
HEART - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:			
Heart Disease?			
High Blood Pressure?			
Treated for a Heart Condition?			
Unusually cold or bluish-colored hands?			
Rheumatic fever or heart murmur?			
Have you ever passed out or nearly passed out during or after exercise?			
Discomfort, pain, or pressure in your chest during exercise?			
Does your heart race or skip beats?			

Name:			Date:
	Yes	No	IF YES, GIVE DETAILS
Has a doctor ever told you that you have high blood pressure, high cholesterol, or a heart infection?			
If yes, how was it treated?	☐ Medicine ☐ Diet ☐ Exercise		
Has a doctor ever ordered a test for your heart (e.g., EKG, echocardiogram, stress test, heart catheterization)?			
Phlebitis, varicose veins, or blood clots/poor circulation?			
Has anyone in your family ever died for no apparent reason?			
Does anyone in your family have a heart problem?			
Has anyone in your family died of heart problems or of sudden death before age 50?			
Have you ever refused any medical treatment for any heart related problem (i.e., for high blood pressure, high cholesterol, coronary artery disease?)			
LUNGS - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:			
Asthma or wheezing:			
Positive skin test for TB?			
Have you been exposed to someone who has TB?			
Pleurisy?			
More than three episodes of bronchitis in one year?			
Had a chest x-ray?			**Date:**
Have you ever refused any medical treatment for any lung related disorder (i.e., asthma, bronchitis pneumonia)?			
MUSCLE-SKELETAL - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:			
Arthritis, rheumatism, neck, back, or spine injury or disease?			
Herniated disc?			
Been treated for a back problem?			
Recurrent stiffness or back pain?			
Bursitis, tendonitis?			
Recurrent pulled muscles or sprains?			
Hand or wrist injury or problem?			

Name:			Date:
	Yes	No	**IF YES, GIVE DETAILS**
Hip or knee injury or problem?			
Ankle or foot injury or problem?			
A job requiring heavy lifting or standing or sitting for long periods of time?			
Any broken bones? Please list.			
SURGERIES/OPERATIONS - HAVE YOU EVER HAD ANY :			
On your back, arm, leg, knee?			
To treat a hernia?			
Varicose veins?			
Other operations?			
Have you ever been hospitalized?			
BLOOD - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:			
Hepatitis A,B, C, Other			
Had a Blood Transfusion ever?			**When?**
			Why?
Has a bleeding disorder or Anemia?			
Vomiting up blood?			
Blood or Black Tarry bowel movements?			
Blood in urine?			
Frequent nose bleeds?			

Comments:

____

____

____

____

____

I, the undersigned, do hereby certify that to the best of my knowledge, the answers I have given to the questions above are true and that I have no physical impairments except as stated above. I understand that any intentional omission or falsification of answers either verbally or in writing above may result in termination of my employment.

APPLICANT'S SIGNATURE ______________________________ DATE: ________________

FINANCIAL AND ADMINISTRATIVE SERVICES

SOCIAL SECURITY NUMBER COLLECTION DISCLOSURE

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

The County of Volusia Division of Risk Management 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 SSN disclosure statement:

Signature: ______________________________ Printed Name: ______________________________

Date: ______________________________

VOLUSIA COUNTY RISK MANAGEMENT
Employment-Related Drug Information and Consent Form for Drug Usage Urinalysis and Physical Exam

The Undersigned agrees as follows:

1. I consent for Risk Management to provide me with a complete physical examination including, but not limited, all items required, including a drug urinalysis, on the standard county physical form and do hereby consent to said physical.

2. I authorize the release of the results of said physical examination to Volusia County Government, State Agencies required to certify certain employees, and to private physicians if needed for consultation.

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

4. It is also understood that employment with the County of Volusia is dependent upon the successful completion of the physical examination.

5. 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 any intentional omission of falsification of answers either verbally or in writing may result in termination of employment.

____
Signed

____
Date

As the parent or guardian of ______________________________________, the minor to be served by Volusia County Risk Management, I request and consent to all of the above for and on behalf of said minor.

____
Parent/Guardian

____
Relationship (e.g. Father, Mother, Guardian)

____
Date

FINANCIAL AND ADMINISTRATIVE SERVICES

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Dr: ______________________________

Fax#: ______________________________

Date: ______________________________

TO WHOM IT MAY CONCERN:

I hereby authorize the health care provider to furnish to the COUNTY OF VOLUSIA, all of my treatment records (including, but not limited to, reports, evaluations, x-rays, M.R.I.'s or other diagnostic tools, prescriptions, progress notes, order sheets, admission forms, laboratory reports, nurses notes, incident reports, consultation records, opinions, records pertaining to HIV or sexually transmitted diseases, and substance abuse).

I agree that a photocopy of this authorization will have the same force and effect as the original. This authorization is limited neither in time nor medical subject area.

Signature: ______________________________________

Printed Name: ______________________________________

Date of Birth: ________________**SSN:**__________________