



**Annual Physical/Fitness for Duty Instructions
For Current County Employees**

(For general non-bargaining employees, Fire Captains, and certain employees of the Sheriff's Office)

You have been scheduled for an annual physical and/or fitness for duty assessment at Personnel's Occupational Health Clinic office, 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 forms that must be filled out prior to your appointment:

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

To prepare for your appointment at the clinic, you must:

1. plan to arrive at least 15 minutes prior to scheduled appointment time;
2. bring a list of all medications you're currently taking; and,
3. bring your state-issued driver's license or other state-issued picture identification card.

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 he/she is 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 approx. 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 Personnel's Occupational Health Clinic section at (386) 736-5984.



Drug, Alcohol, and Nicotine Test Acknowledgement Form

I understand that testing for the presence of chemical substances or metabolites (legal and illegal drugs), alcohol and/or nicotine 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, alcohol and/or nicotine 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.

Special Risk Positions

I understand that if I am in a special risk position (see page 2), it is a condition of my employment that I cannot consume nicotine at any time (on or off duty) during my employment at the County of Volusia. I also understand that if I have a confirmed positive nicotine test during my probationary period, I will be automatically terminated. If I have completed my probationary period and have a confirmed positive nicotine test at any time during my employment at the County of Volusia, I will be subject to disciplinary action up to and including termination.

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 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 non-prescription 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, alcohol, and/or nicotine test.

Print Applicant/Employee Name

Signature

Date

Applicants or volunteers under age 18 require a parent or legal guardian's signature.

Print Parent/Legal Guardian Name

Signature

Date

Special Risk Positions

Below are the special risk positions where employees hired shall be non-tobacco users at the time of hire as a condition of employment and shall be required, as an absolute condition of employment, to refrain from use of tobacco products of any kind, on or off duty, during employment with the County of Volusia.

<p>Beach Safety</p> <p>Beach Deputy Chief Beach Director Beach Safety Specialist Lifeguard Supervisor Senior Lifeguard</p>	<p>Corrections</p> <p>Corrections Assistant Director Corrections Captain Corrections Director Corrections Lieutenant Corrections Officer Corrections Officer Trainee Corrections Sergeant Senior Corrections Officer Warden</p>
<p>Emergency Medical Services (EVAC)</p> <p>Emergency Medical Technician Lieutenant Paramedic Paramedic Sergeant Paramedic</p>	<p>Fire Services</p> <p>Deputy Fire Chief Fire Division Officer Fire Inspector Fire Services Director Career Firefighters Fire Lieutenants Fire Captains</p>
<p>Sheriff</p> <p>Captain Deputy I & II Flight Paramedic Internal Investigator Lieutenant Reserve Officer Sergeant Sheriff</p>	



**PERSONNEL'S OCCUPATIONAL HEALTH CLINIC
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		
<i>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.</i>		
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

<u>DO YOU HAVE OR EVER HAD THE FOLLOWING?</u>	<u>YES</u>	<u>NO</u>	<u>IF YES, GIVE DETAILS</u>
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	<u>IF YES, GIVE DETAILS</u>
Have you had convulsions or seizures or 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 <u>ever</u> 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?			
<u>HEART - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:</u>			
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	<u>IF YES, GIVE DETAILS</u>
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?)			
<u>LUNGS - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:</u>			
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)?			
<u>MUSCLE-SKELETAL - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:</u>			
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	<u>IF YES, GIVE DETAILS</u>
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.			
<u>SURGERIES/OPERATIONS - HAVE YOU EVER HAD ANY :</u>			
On your back, arm, leg, knee?			
To treat a hernia?			
Varicose veins?			
Other operations?			
Have you ever been hospitalized?			
<u>BLOOD - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:</u>			
Hepatitis A,B, C, Other			
Had a Blood Transfusion <u>ever</u> ?			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:



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 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. 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 Personnel 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 clinic personnel to release my medical records concerning my job duties to my employer. This authorization is required in order to meet 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



PERSONNEL OCCUPATIONAL HEALTH CLINIC

RESPIRATORY HISTORY AND SPIROMETRY

EMPLOYEE NAME: _____ SSN: _____

1. Current job or position: _____

Have you ever had or currently have any of the following? (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 your 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: _____



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 Personnel 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 SSN disclosure statement:

Signature

Printed Name

Date