Annual Medical Statement of Personnel

This form is designed to provide the individual in charge of all personnel a complete history of physical status as of the date indicated without the need for expensive physical examinations. Member participation in completing this form is not mandatory but is encouraged on an annual basis for all drivers of emergency vehicles as well as other employees.

Member Name: _____ Today's Date: _____

Address: _____ Birth Date: _____

City & State: _____ Zip: _____

Full Time Occupation: _____

Name of Organization: _____

Position/Title: _____

Member ID#: _____

Instructions: Check "Yes" or "No" to the following questions. If any question is answered "Yes," please provide further details in the "remarks" section. Please provide dates, symptoms, duration, treatment results, names and addresses of doctors, hospitals, etc. where pertinent.

		YES	NO	REMARKS
1.	**EYESIGHT**			
a.	Have you lost use of either eye?	☐	☐	
b.	Is peripheral (side) vision restricted?	☐	☐	
c.	Is color perception impaired?	☐	☐	
d.	Do you have, or have you ever had Cataracts?	☐	☐	
e.	Are actual deficiencies corrected by glasses or contact lenses?	☐	☐	
f.	Date of last eye examination:			
2.	**HEARING**			
a.	Do you have difficulty hearing at a normal conversation level?	☐	☐	
b.	Do you use a hearing aid?	☐	☐	

DISCLAIMER: This is a sample guideline furnished to you by VFIS. Your organization should review this guideline and make the necessary modifications to meet your organization's needs. The intent of this guideline is to assist you in reducing exposure to the risk of injury, harm, or damage to personnel, property, and the general public. For additional information on this topic, contact your VFIS Risk Control Representative at (800) 233-1957.

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		YES	NO	REMARKS
3.	**DIABETES**			
a.	Have you ever been treated for Diabetes?	☐	☐	
b.	Describe current medication and dosage, if any, and method of administration:			
c.	Date of latest blood sugar test:			
4.	**HEART**			
a.	Have you ever been treated for Heart Disease?	☐	☐	
b.	Describe condition:			
c.	Describe current medication and dosage, if any:			
d.	Do you have a pacemaker?	☐	☐	
e.	Date of last treatment or check-up:			
5.	**EPILEPSY**			
a.	Have you ever been treated for Epilepsy?	☐	☐	
b.	If "Yes," when was your last seizure?	☐	☐	
c.	Describe current medication and dosage, if any:			
6.	**LUNGS**			
a.	Have you ever been treated for Asthma or COPD?	☐	☐	
b.	Describe condition:			
c.	Describe current medication and dosage, if any:			
d.	Date of last treatment or check-up:			
7.	BLOOD PRESSURE			
a.	Have you ever been treated for High Blood Pressure?	☐	☐	
b.	If "Yes," when were you treated?			

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		YES	NO	REMARKS
c.	What was your last reading?			
d.	Describe current medication and dosage, if any:			
8.	**LIMBS**			
a.	Have you lost an arm or leg?	☐	☐	
b.	Have you lost the use of an arm or leg?	☐	☐	
c.	Does vehicle have special controls?	☐	☐	
d.	If "Yes," to any of the above, describe:			
9.	**MISCELLANEOUS**			
a.	Have you ever had, or been treated for, Convulsions?	☐	☐	
b.	If "Yes," give date of last treatment and describe current medication and dosage, if any:			
c.	Have you ever had any Fainting Spells?	☐	☐	
d.	If "Yes," give date of last treatment and describe current medication and dosage, if any:			
e.	Have you ever had, or been treated for, Loss of Equilibrium?	☐	☐	
f.	If "Yes," give date of last treatment and describe current medication and dosage, if any:			
g.	Have you ever been treated for Alcohol or Drug Abuse?	☐	☐	
h.	If "Yes," give date of last treatment and describe current medication and dosage, if any:			
i.	Have you ever been treated for Mental Illness?	☐	☐	
j.	If "Yes," give date of last treatment and describe current medication and dosage, if any:			

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		YES	NO	REMARKS
10.	What was the date of your last physical examination?			
11.	Are there any restrictions posted on your vehicle operator's license?	☐	☐	
12.	Are you under the care of a physician for any condition not mentioned above that may affect your ability to operate a motor vehicle?	☐	☐	
13.	When and for what purpose did you last consult a doctor?			

The answers to the above are complete, accurate and true to the best of my knowledge.

Member's Signature _____ Date _____

Consent to Participate

I hereby acknowledge that this form is voluntary and that all information provided by me to the agency will be utilized solely to alert the agency of any health conditions that may affect my ability to perform my job duties. I understand that this information is not required but may help the agency make determinations on any work restrictions that will help to better support the agency's mission. I further acknowledge that the information provided on this form will be held confidential and will not be shared with any party other than agency management.

Member's Signature _____ Date _____

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