WORKSITE+WELLNESS
OCCUPATIONAL HEALTH SERVICES, LLC

New Examinee Registration/Consent

PLEASE COMPLETE ALL SECTIONS PRIOR TO YOUR APPOINTMENT.
Incomplete forms or missing information may result in a delay clearing you for firefighter duties.

Examinee Demographics			
Name:	DOB:	Age:	Gender: ___ M ___F
Address:	City:	State:	Zip:
Personal Phone: / Work Phone:	Email:		

Type of Exam:
_____New Hire/Pre-Employment Comprehensive NFPA 1582 Examination
_____New Hire/Pre-Employment Basic NFPA 1582 Examination
_____Annual Comprehensive NFPA 1582 Examination
_____Annual Basic NFPA 1582 Examination
_____Other:_____

Cities are not required by federal or state laws to administer pre-employment/annual medical examinations or physical ability tests for firefighters or police officers. Even the Occupational Safety and Health Administration Respiratory Protection Standard does not require a complete medical examination for firefighters, but does require a medical questionnaire, medical screening, and fit test to determine if a firefighter can wear a respirator.

Cities may administer medical examinations or physical ability tests so long as the tests do not have an adverse impact on a protected class (42 U.S.C., Section 2000 e-(h)). A protected class would be persons protected by the Federal Civil Rights Act by virtue of their age, race, color, religion, sex, or national origin or the Americans with Disabilities Act.

The National Fire Protection Association (NFPA) develops consensus standards relating to aspects of the fire service. These consensus standards are not law, but they are a nationally recognized standard that outline best practices. More specifically, NFPA 1582 Standard on Comprehensive Occupational Medical Program for Fire Departments sets a framework for pre-hire and incumbent members of the fire service.

Your fire department has recognized the significant impact your job places on your health, and has opted to participate in an occupational program to ensure all employees are evaluated on an annual basis for changes to healthcare baselines.

Consent for Evaluation and Screening Services:

This history & review does not substitute for routine health care or a periodic health examination conducted by your primary medical provider. The physical examination and screening services are being conducted for occupational purposes only. I certify that all the information I have provided on this form is complete and accurate to the best of my knowledge. I hereby consent to Worksite Wellness Occupational Health Services, LLC performing pre-placement/annual screening services requested by my prospective/current employer. All information relative to the screening services, will be used and maintained in strict conformity with the law. I authorize release of information within this form to my employer's DER Designated Employee Representative) or their representative for the purpose of fit for duty clearance as a firefighter. I understand that this authorization will remain in effect until Worksite Wellness Occupational Health Services, LLC receives communication in writing revoking this authorization.

Print Name:_____ Signature: _____
_____

Name: DOB:

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Examinee Health History

Please check (Y) Yes or (N) No to indicate if you have any of the following health/medical history.

Head (Section 6.3.1)

Y	N	
		Defect of the skull (congenital or traumatic)
		Defect of the facial bones (congenital or traumatic)
		Any significant head trauma
		History of surgery of the head

Neck (Section 6.3.2 7.7.20)

Y	N	
		History of thoracic outlet syndrome, cervical disc compression or arthritis of the neck
		Congenital cysts, chronic draining fistulas or lesions
		Chronic neck pain
		History of neck surgery

Eyes/Vision (Section 6.3.3)

Y	N	
		Use of corrective lenses _____Glasses _____Contacts
		History of monochromatic color blindness
		Monocular vision
		History of retinal detachment, progressive retinopathy, or optic neuritis
		Vision changes in the last 6 months
		History of eye surgery

Ears/Hearing (Section 6.3.4 & 7.7.3)

Y	N	
		Chronic hearing loss or use of hearing aides
		Chronic or recurrent Otitis Media or Otitis Externa
		History of atresia, stenosis, or tumor of the auditory canal
		Mastoiditis or surgical deformity of the mastoid
		History of Meniere's Disease, vertigo, labyrinthitis, or tinnitus
		History of surgery of the ears or to correct/improve hearing

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Throat (Section 6.3.6)

Y	N	
		Recurrent or chronic sore throat
		Difficulty swallowing or painful swallowing
		History of dysphonia (chronic hoarseness to your voice)
		History of aphonia (loss of speech due to disease or injury)
		History of oropharyngeal, tracheal, esophageal, or laryngeal conditions
		History of surgery of the throat

Nose (Section 6.3.6)

Y	N	
		History of chronic nasal or sinus conditions
		History of anosmia (loss of smell)
		History of nasal or sinus surgery

Dental (Section 6.3.5 & 7.7.19)

Y	N	
		History of diseases of the jaw or associated tissues
		Any use of orthodontic appliances

Abdomen & GI System (Section 6.7, 7.7.2, 7.7.13 & 7.7.18)

Y	N	
		History of chronic GI disease
		History of GI bleeding
		History of hepatitis
		History of abdominal or GI surgery

Lungs & Chest Wall (Section 6.4, 7.7.4, 7.7.15 & 7.7.22)/(Section 6.4, 7.7.5 & 7.7.8)

Y	N	
		History of chronic lung disease (Asthma, COPD, emphysema, or chronic bronchitis)
		History of pulmonary hypertension
		History of pulmonary vascular disease or pulmonary embolism
		History of hemothorax or pneumothorax
		History of pulmonary surgery

Heart & Vascular System (Section 6.5, 7.7.6, 7.7.7, & 7.7.23)

Y	N	
		History of Coronary Artery Disease
		History of cardiomyopathy or congestive heart failure

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Heart & Vascular System (Section 6.5, 7.7.6, 7.7.7, & 7.7.23)

Y	N	
		Chronic peripheral edema (swelling in the legs)
		Dyspnea on exertion (difficulty breathing with activity)
		Irregular heart beat or feeling like "your heart skips a beat"
		Syncope or near syncope
		History of pericarditis, endocarditis, or myocarditis
		History of valvular heart disease
		History of SVT, 3rd Degree heart block, A-Fib, tachycardia, fibrillation or flutter
		Have you ever had a cardiac stress test
		History of elevated blood pressure or diagnosis of hypertension
		History of PVD (peripheral vascular disease)
		History of thrombophlebitis, thrombosis, or varicosities
		History of heart surgery or cardiac procedures

Spine & Axial Skeleton (Section 6.8)

Y	N	
		History of scoliosis
		Chronic back pain
		Fracture of the spine (cervical, thoracic, lumbar, sacrum, or coccyx)
		History of spine surgery
		Congenital or developmental malformations of the spine

Systemic Diseases (Section 6.13)

Y	N	
		Connective tissue disorders such as, Lupus, scleroderma, or rheumatoid arthritis
		History of thermal, chemical, or electrical burn injury with residual functional deficit
		History of heat illness, rhabdomyolysis, metabolic acidosis, or heat-related incapacitation

Upper Extremities (Section 6.9)

Y	N	
		History of joint replacement or upper extremity surgery
		Chronic pain to the shoulders, elbows, or wrists
		Loss of range of motion of one or both extremities
		Loss of sensation to one or both extremities
		Amputation of limb, or congenital absence of limb

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Upper Extremities (Section 6.9)

Y	N	
		Amputation or congenital loss of thumb or fingers
		History of shoulder dislocation

Lower Extremities (Section 6.9)

Y	N	
		History of joint replacement or lower extremity surgery
		Chronic pain to the hips, knees, ankles, or feet
		Loss of range of motion of one or both extremities
		Loss of sensation to one or both extremities
		Amputation of limb, or congenital absence of limb
		Amputation or congenital loss of great toe or lesser toes

Chemicals, Drugs & Medications (Section 6.11 & 7.7.12)

Y	N	
		Any use of narcotics, including methadone
		Any use of anticoagulants
		Any use of Beta-blockers
		Any use of diuretics
		Any use of inhaled respiratory medications
		Any use of corticosteroids for chronic disease
		Any use of anabolic steroids

Neurologic System (Section 6.10, 7.7, & 7.7.12)

Y	N	
		History of Epilepsy or single unprovoked seizure
		History of TIA or ischemic stroke
		History of Hemi-paralysis or paralysis of a limb
		History of MS, Parkinson's disease, Myasthenia gravis, Progressive muscular dystrophy or atrophy
		History of Dementia
		Narcolepsy
		Amyotrophic lateral sclerosis (ALS)
		Migraine headaches
		Any other neurologic condition not listed above

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Reproductive System (Section 6.12, 7.7.14, 7.7.16, & 7.7.17)

Y	N	
		Women: Currently pregnant
		Women: Dysmenorrhea, endometriosis, ovarian cysts, or other gynecological condition
		Women: Date of last pap smear_____ Date of last mammogram_____
		Women: History of abnormal pap smear (Cervical Cancer screening)
		Women: History of abnormal mammogram
		Men: Testicular pain or epididymal mass
		Men: History of testicular cancer
		Men: History of undescended testicle, testicular torsion, or any testicular surgey

Skin (Section 6.16 & 7.7.21)

Y	N	
		History of metastatic or locally extensive basal or squamous cell carcinoma or melanoma
		Any skin condition that would not allow for a successful fit test for any respirator

Urinary System (Section 6.14 & 7.7.21)

Y	N	
		History of renal failure or renal insufficiency requiring dialysis
		History of diseases of the kidney, ureter, bladder or prostate

Infectious Disease (Section 6.15, 7.7.9, & 7.7.10)

Y	N	
		History of chronic infectious diseases such as HIV, Hepatitis C, Hepatitis B

Heat & Stress Illness (Section 6.18)

Y	N	
		History of connective tissue disease, Lupus, or scleroderma
		History of thermal, chemical, or electrical burn injury
		History of heat stress, rhabdomyolysis, metabolic acidosis, or exertion related incapacitation

Blood & Blood Forming Organs (Section 6.17)

Y	N	
		History of hemorrhagic states requiring replacement therapy
		Sickle cell disease
		Clotting disorders
		History of anemia, leukopenia, polycythemia vera, splenomegaly, or thromboembolic disease

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Tumors & Malignant Diseases (Section 6.19, 7.7.23, 7.7.13, & 7.7.21)

Y	N	
		History of malignant disease (Cancer) Please explain:
		Are you currently undergoing cancer treatment

Psychiatric Conditions (Section 6.20, 7.7.24, & 7.7.26)

Y	N	
		History of depression, anxiety or any other psychiatric condition
		Have you ever been hospitalized due to any psychiatric condition
		History of substance abuse

Medication/Allergy List

Current Medications:			
Medication Name	Dose	Frequency	Comments

Allergies		
Allergy	Reaction	Comments

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Infectious Disease Screening

Hepatitis B	Y	N
Have you completed the 3 dose Hep B Series?		
Do you know your immune status? ____Immune ____Not Immune ____Non-convertor		
Have you been diagnosed with Hepatitis B? If yes, date of diagnosis:_____		
Comments:		

HIV	Y	N
Have you been diagnosed with HIV? If yes, date of diagnosis:_____		
Are you currently on PrEP for HIV prophylaxis? If yes, medication:_____		
Comments:		

Hepatitis C	Y	N
Have you been diagnosed with Hepatitis C? If yes, date of diagnosis:_____		
Are you being treated for Hepatitis C? If yes, medication:_____		
Comments:		

Name: **DOB:**

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Tuberculosis Screening

NFPA 1582 Guidelines: Baseline screening by either TB skin testing using PPD or IGRA blood tests such as Quantiferon TB Gold. Subsequent TB screening to be performed annually or at a frequency according to CDC guidelines.

	Y	N
Have you ever had a positive TB skin test? (If yes, please provide date:)_____		
Have you ever had to have a chest x-ray due to a positive TB test? (If yes, please provide date:)_____ Results of CXR:_____		
Have you ever had to be referred to the Health Department for a positive TB test? (If yes, please provide date:)_____		
Have you ever been diagnosed with Latent TB Infection? (If yes, please provide date:)_____		
Have you ever been diagnosed with Active TB Infection? (If yes, please provide date:)_____		
Have you ever had close contact with anyone who was sick with TB? (If yes, please explain:)_____		
Were you born outside of the U.S.? (If yes, please list the country)_____		
Have you ever been vaccinated with BCG? (If yes, please provide date:)_____		
Have you traveled outside of the U.S. in the last year? (If yes, please list the country)_____		
Do you currently have any of the following symptoms?		
A cough that lasts longer than three weeks		
Coughing up blood or sputum (a thick mucus from the lungs)?		
Chest pain?		
Night sweats (heavy sweating during sleep)?		
Losing weight without trying?		
Loss of appetite?		
Weakness or fatigue?		

Recommendation:

_____Administer TB Screening with Quantiferon TB Gold
_____Chest X-ray needed
_____Refer to Health Department for evaluation for LTBI Evaluation

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Employee Comments:

Provider Comments:

Provider Name: Robin Horaz, FNP-BC Provider Signature:_____