Attachment 9

Ohio | Department of Veterans Services

Mike DeWine, Governor
Deborah Ashenhurst, Director

# Pre-Employment Physical Examination

| Applicant Name (Last, First Middle) | | | Family Physician's Name | | |
|---|---|---|---|---|---|
| Examining Physician's Name | Height | Weight | Temperature | Pulse | Blood Pressure |
| Laboratory Tests By: (Date) | | | Chest X-Ray: (Date) | | |

| | | Normal | Abnormal | Remarks |
|---|---|---|---|---|
| General Appearance | | | | |
| Mental Status | | | | |
| Head | Eyes | | | |
| | Ears | | | |
| | Nose | | | |
| | Throat | | | |
| Neck (Thyroid) | | | | |
| Chest | Lungs | | | |
| | Heart | | | |
| Abdomen | | | | |
| Neuro-Muscular | Neck | | | |
| | Upper-Back | | | |
| | Lower-Back | | | |
| | Extremities | | | |
| Genito-Urinary | | | | |
| Reflexes | | | | |
| Skin | | | | |
| Lymphatics | | | | |

The above applicant was examined on (date)_____and has been found physically and mentally fit to perform duties as_____ _ _____•

Exceptions:_____

_____

_____
Examining Physician's Signature

Date

# Medical History

Handicaps (ORC: 4123.343): (check al! that apply)

□ Epilepsy □ Diabetes □ Cardiac Disease □Arthritis □ Amputated foot, leg, arm or hand □ Residual disability from Poliomyelitis □ Cerebral Palsy □ Multiple Sclerosis □ Parkinson's Disease □ Cerebral Vascular Accident □ Tuberculosis □ Silicosis

□ Hemophilia O Chronic Osteo-myelitis O Ankyloses of Joints D Hyper Insulinism □ Muscular Distrophies O Anterio-Sclerosis

□ Thrombo-Phlebitis □ Varicose Veins □ Coal miner's Pneumoconiosis commonly referred to as "black lung disease"

□ Cardiovascular, Pulmonary or respiratory diseases of a fire fighter or police officer employed by a municipal corporation or township as a regular member of a lawfully consulted police department or fire department

□ Disability with respect to which an individual has completed a rehabilitation program conducted pursuant to sections 4121.61 to 4121.69 of the Ohio Revised Code

□ Loss of sight of one or both eyes or a partial loss of uncorrected vision of more than 75% bilaterally

□ Other (soecifv)

Past Illnesses:

Back injuries:

Allergies:

Operations:

Medications:

Prior claims on Worker's Compensation or Occupational Injury Pay, etc. (please identify the employer, claim number and the injured part of the body}:

I,_____(print name), affirm that the above information pertaining to my medical history is complete and true to the best of my knowledge. I understand that the falsification of the aforementioned information will be considered grounds for dismissal.

Applicant Signature Date