Dear Lower Macungie Fire Department Member,

To speed up the medical physicals process, I have copied forms, which are the same ones that need to be filled out at the doctor's office. If you would like, you may fill them out prior to going to your appointment. Please be sure to keep these pages in the order that you receive them. It will make the process go faster and easier for the staff at Health Works and LVH Diagnostic. I hope this helps out and makes the whole medical physicals process easier for you all.

Please be sure to emphasize that you are with **Lower Macungie Fire Department (formerly Wescosville)** and that you will be getting the cholesterol screening. Not all of the call takers are aware of this and they also confuse us with Macungie Fire Department.

Sincerely,

Andrew M. Miller

Andrew M. Miller
EMS Coordinator
Lower Macungie Fire Department

Lower Macungie Fire Department
Annual Medical / Physical Procedure

Dear ,

As per our SOPs, all LMFD personnel are required to complete the following steps during the month of his/her birthday. Our records indicate that your birthday month, so your physical will be due by the end of the month. Please remember that if you do not get your physical by this time, you will not be able to use an air pack for the following year. You also will not be invested in the pension or incentive programs for that year. **Please note: work physicals will not be accepted as a replacement for the fire fighter medicals.**

Step 1: Schedule an appointment at LVH Diagnostic Care Center

Firefighters and Fire Police shall report here for blood work, urinalysis, EKG and chest X-ray (if due).

Call (610) 402-8378 Option #1for English then option 4 for preadmission testing to schedule the appointment. Be sure to mention that you are a member of **Lower Macungie** FD (They tend to confuse us with Macungie FD) and a participant in the fire department Medical Surveillance program. Appointments may be scheduled for Tue, Wed, and Fri 0800-1500 and Thursday 10am- 1800. This is a fasting blood work so you can't have anything to eat or drink 10-12 hrs. prior to blood work, so morning would probably be best if you can. These are the **only** times available so try to schedule your appointment appropriately. LVH requests that appointments be scheduled at least 2 days in advance. Allow about 30-45 minutes to complete the check-in and testing.
Enter through the main lobby of LVH Cedar Crest & I-78. Turn left and follow the signs for the Jandl Pavilion. Once in the Jandl Pavilion, report to the Diagnostic Care center on the first floor, past the elevators, and register with the receptionist.

Step 2: Schedule an appointment at Health Works (Affinity).

Firefighters and Fire Police shall schedule their physical exam, pulmonary spironetry, and audiometry at Health Works (Affinity) 14 days after their laboratory testing.

Call (610) 402-9285 to schedule the appointment. Be sure to mention that you are a member of LMFD and a participant in the Fire Department Medical Surveillance program. Appointments may be scheduled Monday through Friday between 07:30 and 17:30 hours.

Report to Health Works (Affinity) at 1243 South Cedar Crest Blvd. 1st Floor.

If you have any questions or problems, please contact Andrew Miller at (951)295-0727 (Cell).

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE

Welcome to HealthWorks

Fire Police

REGISTRATION FORM

- ☐ Healthworks Allentown
- ☐ HealthWorks Bethlehem
- ☐ HealthWorks Easton
- ☐ HealthWorks Trexlertown

Please print in blocks below questions. Thank you.

PATIENT INFORMATION

Last name:	First:	MI:

Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:
☐ Yes ☐ No			/ /		☐ M ☐ F

Home phone #:	Cell phone #:	Social Security #:
( )	( )	- -

Street address:

City:	State:	ZIP Code:

EMPLOYER INFORMATION

*****Please list the Employer who requested that you come to HealthWorks. If a Temporary Agency sent you, list them as the Employer. If paying for services yourself, leave employer information blank. *****

Company/Employer Name:	Employer address:	Name of Company Contact:
Lower Macungie FD	958 Brookside Rd Wescosville, PA 18106	Andrew Miller

Employer phone #:	If working for a temporary employment agency, list where you will be working, if known.	Job Title:	Shift- 1st, 2nd, 3rd
(951) 295 0727			N/A

IN CASE OF EMERGENCY

Name of relative or friend to be called in case of an emergency:	Relationship to patient:	Cell phone #:	Work or Home phone #:
		( )	( )

☐ Check this box if your emergency contact's address is the same as yours.
If different, please record their address below.

Street address:	City:	State:	ZIP Code:

LEHIGH VALLEY HOSPITAL
ALLENTOWN, PA

LEHIGH VALLEY HOSPITAL – MUHLENBERG
BETHLEHEM, PA

FAIRGROUNDS SURGICAL CENTER
LVHN SURGERY CENTER – TILGHMAN
LVHN CHILDREN'S SURGERY CENTER
ALLENTOWN, PA

Name:_____

Date of Birth:_____

CONSENT FOR TREATMENT

CONSENT FOR TREATMENT: I grant authorization to Lehigh Valley Health Network (LVHN) and all its physicians and staff whether employed directly by LVHN or brought in on a consulting basis, for all such treatment and procedures as may be necessary for the patient herein named in accordance with the judgement of the attending physician. I understand that LVHN utilizes telehealth/telemedicine technologies including digital photography, interactive audio and/or video, cloud-based storage and other types of secure HIPAA compliant technologies. Photographs, interactive video, and/or audio may be taken and/or utilized during my stay for treatment reasons or for monitoring my safety. Photographs may become part of my medical record, as appropriate. I acknowledge that no guarantees have been made as to the results of treatments or examinations in the LVHN, or otherwise. I realize that I have the right to refuse any drugs, treatment, procedures or photographs to the extent permitted by law.

AUTHORITY TO REVIEW AND RELEASE RECORDS AND INFORMATION: Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality, and to coordinate patient care across the provider network, avoiding duplication of services. LVHN has a system-wide electronic medical record that is available to caregivers, on a "need to know" basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards. Patient care summaries are automatically sent to designated Lehigh Valley Physician Group and other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. LVHN and/or the attending physician can furnish and release to federal and state healthcare oversight agencies or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record.

AUTHORITY TO RELEASE LOCATION AND GENERAL CONDITION: As a patient, you have the option to be listed in the LVHN public information directory. If you elect not to be listed ("Do Not Announce") your presence will not be acknowledged and mail, telephone calls, flowers and visitors will be refused. Being listed in the public information directory means that your room number, telephone numbers and general condition can be released in matter of public record.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I understand and have been made aware that the Hospital provides facilities for the safekeeping of valuables. I release the Hospital from any responsibility due to loss or damage of any valuables that the patient or the undersigned may keep in his possession in the room, or at the bedside, including those valuables that may be brought to him by other persons.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges incurred by and for the named patient from the date admission/service. I agree to make payment in full immediately upon receipt of billings, whether interim or final billings. In the event that the undersigned fails to make payment as provided herein or agrees to alternate arrangements deemed satisfactory by LVHN, affirmative collection measures will be initiated. I agree to pay all costs of collection, including fifteen (15%) percent of the unpaid balance as a reasonable attorney's fees in the event that such indebtedness is turned over to an attorney for collection.

DATA COMPILATION FOR RESEARCH: The undersigned hereby grants authorization for the Hospital to use a patient's health information for the internal purpose of gathering and sorting data (or human tissue) by categories to be available for potential use in research studies. If your information is to be used for a research study, you may be asked to sign additional authorization at that time.

ASSIGNMENT OF BENEFITS: In the event the undersigned is entitled to insurance benefits of any type out of any program health benefit plan or policy of insurance covering the patient or any other party liable to the patient, then such benefits are hereby assigned to LVHN and may be paid directly to the LVHN. In the event benefits are paid, LVHN shall credit all payments to the patients' account; however, the patient and the undersigned, if not the patient, shall remain responsible for any portion of the LVHN bill not covered by this assignment.

PRIVACY NOTICE: I acknowledge receipt of the Health Information Privacy Notice for LVHN and the LVHN Medical Staff on or after April 14, 2003.

PATIENT RIGHTS: I hereby acknowledge receipt of information regarding Patient Rights and the complaint process. I understand that I may contact the Department of Health at 800-254-5164 or the Joint Commission, Office of Quality Monitoring at 800-994-6610 or complaint@jointcommission.org if I want to report concerns about patient safety and quality of care.

_____ I decline a copy of the patient rights.
(initials)

HEALTH INFORMATION EXCHANGES: LVHN may make your health information available electronically through a state, regional, or national Health Information Exchange (HIE) service or through *Care Everywhere*® Network to facilitate the secure exchange of your health information between and among several health care providers or other health care entities for your treatment, payment, or other healthcare operations purposes. This means we may share information we obtain or create about you with a HIE, which will be made available to outside entities (such as hospitals, doctors offices, pharmacies, or insurance companies) or we may receive information they create or obtain about you (such as medication history, medical history, or insurance information) so each entity can provide better treatment and coordination of your healthcare services. In cases where your specific consent or authorization is required to disclose certain health information to others, we will not disclose that health information without first obtaining your consent. Information that requires additional consent in order to be shared includes psychotherapy notes, treatment for substance or alcohol abuse, and records of tests or treatment for sexually transmitted diseases. **IF YOU ARE NOT INTERESTED IN HAVING YOUR HEALTH INFORMATION SHARED WITH OTHER HEALTH CARE PROVIDERS IN THE HIE, PLEASE INITIAL BELOW TO OPT OUT:**

_____ No, I request that my medical information be excluded from *Care Everywhere*®. I understand this means that other health care providers will not
(initials) be able to obtain my health information through *Care Everywhere*® but they may obtain it through other methods.

ACKNOWLEDGEMENT FORM: I certify that I have read this document, that it has been explained and that I understand its contents, and hereby agree to all terms and conditions set forth in paragraphs 1 through 9 set forth above and acknowledges that receipt of a copy if requested.

MEDICAL ASSISTANCE VERIFICATION: My signature certifies that I received a service or item on the date listed below. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements or documents, or concealment of material may be prosecuted under applicable Federal and State laws.

Signature of Patient	Date	Time
Signature of Authorized Representative	Date	Time
Relationship to Patient		
Witness	Date	Time

TB/Fall Risk/DV Questionnaire

Interpreter ID:

Patient Name: _____ **DOB/MRN:** _____

Please circle Yes or No for each question

Fall Risk

1. Do you need anything to help you walk (cane; walker, etc.)? Yes No
2. Do you feel unsteady on your feet? Yes No
3. Have you fallen in the past year? Yes No

TB

Please notify nurse or receptionist IMMEDIATELY if you answer "YES" to two or more of the following questions:

1. Have you been sick with a cough for more than two weeks? Yes No
2. Have you had contact with anyone with tuberculosis or consumption? Yes No
3. Have you ever had tuberculosis or consumption? Yes No
4. Do you have night sweats? Yes No
5. Do you cough up blood? Yes No
6. Have you lost weight recently for no reason? Yes No

DV Screening

1. Do you feel safe in your current relationship? Yes No
2. Is someone making you feel bad about yourself? Yes No
3. Within the last year, have you been hit, kicked, punched or otherwise hurt by someone you know? If so, by whom? Yes No
4. Is there someone who is making you feel unsafe now? Yes No

---

HealthWorks Staff complete below:* *if YES must be assessed by Nursing Staff or Medical Provider*

Fall Screening Complete: _____ *Staff Initial* *Answered Yes to one or more questions: No YES **see documentation*

TB Screening Complete: _____ *Staff Initial* *Answered Yes to two or more questions: No YES ** see documentation*

DV Screening Complete: _____ *Staff Initial* *Answered No to #1 or Yes to questions #2-4 No YES ** see documentation*

Disposition:

Sign, Date & Time: _____

Scan into patient record, Media Manager labeled as TB Fall Risk Questionnaire

Lehigh Valley Health Network

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Consent for Release of Protected Health Information

Section 1: Patient Information

X	PATIENT NAME	SOCIAL SECURITY NO.	DATE OF BIRTH
X	PATIENT ADDRESS STATE ZIP CODE		TELEPHONE NO.

Section 2: Location(s) of Care

☐ Hospital * ☐ LVPG Physician Office ☐ Hospice ☐ Home Health
☒ Outpatient Clinic, Satellite location, or specified site ☐ Other Health Care Facility

Address Of LVPG Physician Office, Hospital Clinic, Satellite location(s), or Other Health Care Facility where you received care:

☒ HealthWorks ☐ Company Facility

*Includes Cedar Crest, Muhlenberg and 17th and Chew Hospital locations.

Section 3: Release Records To:

I hereby consent to and authorize the above entities to release information from my medical record to:

Name of Doctor/Hospital/Insurance Company/Other Agency, Person, or Self: Company/Employer
Lower Macungie Fire Dept

Address: P.O. Box 3002 Wescosville, PA 18106 Fax#:

For the Purpose of: ☐ Continuation of Care ☐ Social Security/Disability ☐ Insurance Purposes

☐ Legal Purposes ☐ Personal Access ☒ Other: Company Request

Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or other confidentiality laws.

Section 4: Specific Information To Be Released

The Information to be released will cover the time period from _____ to _____.

SPECIFIC INFORMATION TO RELEASE:

☐ Record Summary*		
☐ Office Notes/Visit Notes	☐ Discharge Summary	☐ Physician Orders
☐ Immunizations	☐ Operation Reports	☐ Diagnostic Films (x-rays, scans)
☐ Disability/FMLA Form	☐ Pathology Reports	☐ Photographs
☐ Medication List	☐ Consultation Reports	☐ Itemized Bills
☐ Problem List	☐ Laboratory Results	☐ Catheterization Lab
☐ Emergency Room Record	☐ X-Ray Reports	☐ Entire Record (includes records from other facilities)
☐ History & Physical Exams	☐ EKG, EEG, Stress Tests	

☒ Other (specify) Drug collection, Breath Alcohol, Immunizations, Venipuncture, Audiogram, PFT, Respirator Fit Test, Lab Test Results, Vision Testing, History & Physical Exam

☐ **Exception:** I do not give permission to release (specify): _____

* For explanation of Record Summary, see Instructions for Completion.

Consent for Release of Protected Health Information

Section 5: Special Authorizations For Mental Health, Drug and Alcohol and HIV Records

ATTENTION PATIENT: IF APPLICABLE, PLEASE COMPLETE THIS SECTION

I understand that my medical record may contain "protected information" related to the following categories. My signature next to these items acknowledges my awareness and my authorization to release "protected information" in the record.

_____ Signature — Drug or alcohol information, if drug or alcohol tests were ordered or treatment provided by my physician/provider. (Confidential Alcohol and Drug Abuse Patient Information 42 C.F.R. Part II)

_____ Signature — Psychiatric or psychological information, if psychiatric or psychological treatment was given by my physician/provider. (PA Mental Health Procedure Act).

_____ Signature — HIV related information, if HIV-related tests were ordered by my physician/provider. (Confidentiality of HIV-Related Information Act, PA Law Act 148).

Information is being disclosed from records whose confidentiality is protected by Federal Law [42 C.F.R. Part II] and PA State Statutes [Title 55 Pa. Code 5100.32 and 5100.34 (a) and (b) and DAACA, 71 P.S. 1690.108 (b) & (c)].

Section 6: Authorization Signatures

AUTHORIZATION SIGNATURES

I understand that in order to process this request for the reproduction of medical record information on a timely basis, Lehigh Valley Health Network may utilize a contracted medical record copying service, and I further authorize the release of my medical record information to such record service for this purpose. I understand that I do not have to sign this form in order to receive treatment at Lehigh Valley Health Network. **Even though the consent for release of information is valid for 90 days** I also understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that any action that has already been taken as authorized by this form will remain in force in order to achieve the purposes for which it is given. I have a right to request a copy of this authorization. A copy of this authorization is as valid as the original.

Date Consent Expires:_____

X Patient Signature:_____ Date Signed:_____

Signature of Parent/Legal Guardian/Authorized Representative:_____

Printed Name of Parent/Legal Guardian/Authorized Representative:_____

Unable to sign because:_____

Witness signature:_____

☐ Attached is a copy of the appropriate legal document, which proves authority to act on behalf of the patient.

CONTACT INFORMATION, MAILING/FAXING INSTRUCTIONS:
Mail/fax the completed form to the appropriate LVHN location or other facility where you received care as follows:

Hospital, (Inpatient and Outpatient Visits) Records:
Lehigh Valley Health Network - Attn. Release of Information
Cedar Crest and I-78 Box 689
Allentown, PA 18105-1556
Phone: 610-402-8240 Mon.-Fri. 8:30AM to 4:00 PM
Fax: 484-884-3824

Home Care and Hospice Records:
2166 12th Street, Allentown, PA 18103
Phone: 610-969-0300
Fax: 610-969-0454

LVPG Physician Office Records and Satellite Locations:
Mail or fax to the physician office or satellite location where you received care. Please see http://www.lvpg.org for a listing of LVPG physician practice locations. Please see http://lvhn.org for a listing of satellite locations.

Other Facility:
_____
_____
_____

For office use only:
MRN#:_____ Encounter#:_____

Received:_____ Initial and Date ID Confirmed:_____ Initial and Date Completed :_____ Initial and Date

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE

HealthWorks Fire Police

MEDICAL HISTORY

Name: _____ Date of Birth: _____

Position Applied For: _____ Company: _____

APPLICANT/EMPLOYEE HEALTH HISTORY

Yes	No		Yes	No	
☐	☐	1. Any illness or injury in last 5 years	☐	☐	14. Spinal injury or disease
☐	☐	2. Head/Brain injuries, fainting, seizures, loss of consciousness or stroke/paralysis	☐	☐	15. Chronic or ongoing low back pain or neck pain
☐	☐	3. Eye Disorders or impaired vision (except corrective lenses)	☐	☐	16. Missing or impaired hand, arm, foot, leg, finger, or toe
☐	☐	4. Ear disorders, loss of hearing or balance or exposure to loud noise	☐	☐	17. Numbness or tingling of arms, legs, hands or feet
☐	☐	5. Heart disease or heart attack; other cardiovascular condition. _____	☐	☐	18. Sleep disorders, pauses in breathing while asleep, daytime sleepiness or loud snoring
☐	☐	6. Diabetes or elevated blood sugar. Controlled by: _____	☐	☐	20. Regular, frequent alcohol use _____ How much? _____
☐	☐	7. High Blood Pressure	☐	☐	21. Any Narcotic or habit forming drug use? List: _____
☐	☐	8. Muscular disease/joint pain/carpal tunnel syndrome/tendonitis	☐	☐	22. Tobacco use. If yes, how much: _____
☐	☐	9. Shortness of breath	☐	☐	24. Any other complaints, disease or illness: _____
☐	☐	10. Lung disease such as emphysema, asthma, chronic bronchitis	☐	☐	25. Do you have any hobbies? If Yes, please list: _____
☐	☐	11. Kidney disease and/ or dialysis	☐	☐	26. Do you have a hernia or a lump in your groin?
☐	☐	12. Nervous or psychiatric disorders (e.g. depression). _____			27. What jobs or types of work have you performed in the past? Please list: _____ _____
☐	☐	13. Digestive problems/ulcers/colitis or liver disease?			

How much work time have you lost in the last 2 years due to illness or injury? _____

How much work have you missed due to a work injury or illness in the last 5 years? _____

Please list exposures you have had that may pose a health risk: _____

Please list any past surgeries (operations): _____

Please list any allergies: _____

Please list all medications including supplements: _____

I certify that the above information is complete and true. I understand that inaccurate, false, or missing information may invalidate the examination.

Signature _____ Date _____

For Medical provider use only

Please explain all Yes answers, include any effects on job performance:

_____

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.

HealthWorks

PHYSICAL EXAMINATION

Name_____ Date_____

Height_____ Weight_____

Vision with/without correction Far RT_____ LT_____ Both_____

Safety glasses ❑Yes ❑ No Near RT_____ LT_____Both_____

Color_____

Depth Perception_____%

Peripheral RT_____ LT_____

Hearing: Whisper RT_____Feet LT_____Feet
❑ See Audiogram

Blood Pressure_____ Repeat_____

Pulse_____

Urine Dip: Sugar_____ Specific Gravity_____ PH_____ Blood_____ Protein_____

	Normal	Abnormal	Comments		Normal	Abnormal	Comments
Skin				Lungs			
Head				Heart			
Eyes				Abdomen			
Ears				Genitourinary			
Nose				Back			
Throat				Extremities			
Teeth				Nervous System			
Neck							

Findings/Recommendations: Follow-up with personal health care provider for preventative, routine, and on-going evaluation and care.

_____

_____

_____

_____

Medical Examiner (Print)_____ **Signature** _____

Date & Time_____

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE

HealthWorks

AUDIOMETRIC HISTORY

Date: _____

Employee Name: _____ **SSN:** _____ **DOB:** _____ **Sex:** _____

Company Name: _____ **Date of Hire:** _____ **Job Title:** _____

How Do You Rate Your Hearing:
- ❑ Good
- ❑ Fair
- ❑ Poor
- ❑ Difficult to Hear in Crowds
- ❑ Difficult to Hear Safety Alarms

Current Hearing Protection Used:
- ❑ None
- ❑ Ear Plugs
- ❑ Ear Muffs
- ❑ Both Plugs and Muffs
- ❑ Other: _____

Reason For Test:
- ❑ Pre-employment
- ❑ Annual
- ❑ Baseline
- ❑ Retest
- ❑ Exit

Mark an "X" in the NOW, PAST, or NEVER box next to each item:

NOW	PAST	NEVER	
❑	❑	❑	Frequent Earaches
❑	❑	❑	Excessive Ear Ringing (Tinnitus)
❑	❑	❑	Excessive Dizziness (Vertigo)
❑	❑	❑	Head Injury (with unconsciousness)
❑	❑	❑	High Fever (Over 104° F)
❑	❑	❑	Ear Drainage
❑	❑	❑	Ear Surgery Specify: _____
❑	❑	❑	Ear Injury Specify: _____
❑	❑	❑	Sinus Trouble
❑	❑	❑	Allergies/Hay Fever
❑	❑	❑	Hearing Problems from Medication
❑	❑	❑	Ear Infections
❑	❑	❑	Bad Cold Today
❑	❑	❑	Frequent Asthma Attacks
❑	❑	❑	Trouble hearing in Right Ear
❑	❑	❑	Trouble hearing in Left Ear
❑	❑	❑	Hearing Aid: Right _____ Left _____

NON-WORK EXPOSURE TO NOISE: Do/did you have significant exposure to any of the following without hearing protection outside of work? (Mark an "X" in the NOW, PAST, or NEVER box next to each item.

NOW	PAST	NEVER	
❑	❑	❑	Gun Fire
❑	❑	❑	Chainsaws/Power Tools
❑	❑	❑	Heavy Equipment
❑	❑	❑	Aircraft
❑	❑	❑	Hunting
❑	❑	❑	Loud Music
❑	❑	❑	Car Racing
❑	❑	❑	Engine Work/Tractor/Auto
❑	❑	❑	Pilot a Plane

_____

Employee Signature **Date**

OTOSCOPIC EXAMINATION

TO BE COMPLETED BY PHYSICIAN/TECHNICIAN AT TIME OF OTOSCIPIC EXAMINATION.
HAS THE WORKER:

YES	NO	
❑	❑	Been working prior to examination?
❑	❑	Been exposed to noise 14 hours prior to test? If Yes, indicate the number of hours: _____
❑	❑	Had an audiometric test in the last year?
❑	❑	Had an audiometric test over 1 year ago?
❑	❑	It is unknown whether an audiometric test had been performed.

Check N (Normal) or A (Abnormal) for each. If A (Abnormal) is checked, describe the abnormality in the space provided.

	RIGHT	LEFT	DESCRIBE ABNORMAL
External Ear	[N] [A]	[N] [A]	_____
Ear Canal	[N] [A]	[N] [A]	_____
Ear Drum	[N] [A]	[N] [A]	_____

ATTACH AUDIOGRAM

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.

HealthWorks

FIREFIGHTER PHYSICAL NOTIFICATION FORM

Firefighter's Name: _____ Date of Physical: _____

SS# _____ Title: _____

Firefighter Department Name: _____

Hazardous Material Team Member? _____ Yes _____ No

I have examined the above named: _____

_____ He/she is physically fit and cleared to perform assigned duties.

_____ He/she is not physically fit and cleared to perform assigned duties.

_____ He/she is unable to be cleared at this time due to lack of information.

_____ _____

Physician's Signature Date

Comments/follow up recommendations: _____

_____

_____

_____ _____

Physician's Signature Date

***The conclusions of this medical assessment are based, in part, on the assumptions that the medical history and any supplied job description or essential functions of the job are true and correct. The employer is responsible for employment decisions when considering accommodation for those with any limitations or restrictions. If there are any questions or concerns about an individual's abilities to perform tasks, please do not hesitate to contact a representative at HealthWorks.**

1243 S. Cedar Crest Blvd., Allentown, PA 18103 ♦ Phone: 610-402-9285 ♦ Fax: 610-402-9293
1770 Bathgate Dr. Suite 200, Bethlehem, PA 18017 ♦Phone: 484-884-2249 ♦Fax: 484-884-8034
2101 Emrick Boulevard, Bethlehem, PA 18020 ♦ Phone: 610-866-9675 ♦ Fax: 610-865-1472
6900 Hamilton Boulevard, Suite 145, Trexlertown, PA 18087 ♦ Phone: 610-402-0047 ♦ Fax: 610-402-0097