# LOWER MACUNGIE FIRE DEPARTMENT

## ANNUAL MEDICAL/PHYSICAL PROCEDURE

As per our SOPs, all LMFD personnel are required to complete the following steps during the month of their birthday. Please remember that not getting a physical can result in not being eligible for incentives and possibly interior qualification. **Please note: work physicals WILL NOT be accepted as a replacement for the department physical unless other circumstances that have been discussed and approved already.**

**Step 1: Receive email with this paperwork and physical packet to fill out**

**Step 2: Schedule an appointment**

Firefighters and fire police shall schedule their appointments for all tests and physical exams at health works. Phone # 610-402-9285 option#1. When scheduling please let them know you are with the **LOWER MACUNGIE FIRE DEPARTMENT and that it is the ANNUAL TESTING.** Health works Allentown is located at 1243 S. Cedar Crest Blvd 1st floor, Allentown PA 18103.

**Step 3: Arrival to your appointment with all paperwork.**

It is unknown exactly how long it could take but on the safe side I would side with 2 hours for everything but hope it is less.

**If you have any issues or problems, please Contact Andrew Miller 951-295-0727.**

Lehigh Valley Health Network
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# Welcome to HealthWorks

#1

## 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: |
|---|---|---|---|
| | | | |

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# MEDICAL HISTORY

Name: _____ Company _____

Position Applied For: _____

## APPLICANT/EMPLOYEE HEALTH HISTORY

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ❑ | ❑ | Any illness or injury in last 5 years | ❑ | ❑ | Stroke or paralysis |
| ❑ | ❑ | Head/Brain injuries, disorders or illness | | | |
| ❑ | ❑ | Seizures, epilepsy. If Yes, medication _____ | ❑ | ❑ | Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring |
| ❑ | ❑ | Eye Disorders or impaired vision (except corrective lenses) | ❑ | ❑ | Missing or impaired hand, arm, foot, leg, finger, or toe |
| ❑ | ❑ | Ear disorders, loss of hearing or balance | ❑ | ❑ | Numbness or tingling of arms, legs, hands or feet |
| ❑ | ❑ | Heart disease or heart attack; other cardiovascular condition. If Yes, medication: _____ | ❑ | ❑ | Spinal injury or disease |
| ❑ | ❑ | Diabetes or elevated blood sugar Controlled by ____ diet ____ pills ____ insulin | ❑ | ❑ | Have you had any exposure to chemicals, noise or vibration which might cause possible health problems? If yes, please list: _____ |
| ❑ | ❑ | High Blood Pressure. If Yes, Medication: _____ | ❑ | ❑ | Chronic or ongoing low back pain |
| ❑ | ❑ | Muscular disease/joint pain/carpal tunnel syndrome/tendonitis | ❑ | ❑ | Regular, frequent alcohol use |
| ❑ | ❑ | Shortness of breath | ❑ | ❑ | Narcotic or habit forming drug use |
| ❑ | ❑ | Lung disease, emphysema, asthma, chronic bronchitis | ❑ | ❑ | Tobacco use. If yes, how much: _____ |
| ❑ | ❑ | Kidney disease, dialysis | ❑ | ❑ | Any other disease or illness: _____ |
| ❑ | ❑ | Liver disease | ❑ | ❑ | Do you have any hobbies? If Yes, please list: _____ |
| ❑ | ❑ | Digestive problems/ulcers/colitis | | | |
| ❑ | ❑ | Nervous or psychiatric disorders (e.g. severe depression). If Yes, medication _____ _____ | ❑ | ❑ | Do you have any cancer or illness that tends to occur in your family? If Yes, please list: _____ _____ |
| | | | ❑ | ❑ | What jobs or types of work have you performed in the past? Please list _____ _____ |
| ❑ | ❑ | Loss of, or altered consciousness | | | |
| ❑ | ❑ | Fainting, dizziness | | | |

For any Yes answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently. _____ _____

Are you certified to use medical marijuana? ❑ Yes ❑ No _____

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

Please list any past surgeries (operations): _____

Please list any allergies: _____

Have you had (answer Yes or No): Measles ❑ Yes ❑ No Mumps: ❑ Yes ❑ No
German Measles (Rubella): ❑ Yes ❑ No Chicken Pox: ❑ Yes ❑ No

If you were born in 1957, or more recently, have you had 2 measles or MMR immunizations? ❑ Yes ❑ No

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

Signature _____ Date _____

Rev 10/2020

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# 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_____

***Above completed by: Sign/Date/Time:*** _____

| | 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**_____

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# 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**

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# PFT Questionnaire

(Pulmonary Function Test)

| | | |
|---|---|---|
| 1. Have you smoked anything within the past one (1) hour? | Yes | No |
| 2. Have you had a heavy meal within the past two (2) hours? | Yes | No |
| 3. Do you wear dentures? | Yes | No |
| 4. Have you used any aerosol for asthma, etc., within the past two (2) hour? | Yes | No |
| 5. Have you had any flu or upper respiratory symptoms with in the past three (3) week? | Yes | No |
| 6. Have you had any current or chronic ear infections? | Yes | No |
| 7. Have you had surgery recently? | Yes | No |
| 8. How do you feel today? | _____ | |
| 9. Please remove restrictive clothing. | | |

**Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)**

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee: Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:_____

2. Your name:_____

3. Your age (to nearest year):_____

4. Sex (circle one): Male/Female

5. Your height: _____ ft. _____ in.

6. Your weight: _____ lbs.

7. Your job title:_____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____

9. The best time to phone you at this number: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

11. Check the type of respirator you will use (you can check more than one category):
a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
b. _____ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): Yes/No

If "yes," what type(s):_____
_____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month: Yes/No

2. Have you *ever had* any of the following conditions?

a. Seizures: Yes/No

b. Diabetes (sugar disease): Yes/No

c. Allergic reactions that interfere with your breathing: Yes/No

d. Claustrophobia (fear of closed-in places): Yes/No

e. Trouble smelling odors: Yes/No

3. Have you *ever had* any of the following pulmonary or lung problems?

a. Asbestosis: Yes/No

b. Asthma: Yes/No

c. Chronic bronchitis: Yes/No

d. Emphysema: Yes/No

e. Pneumonia: Yes/No

f. Tuberculosis: Yes/No

g. Silicosis: Yes/No

h. Pneumothorax (collapsed lung): Yes/No

i. Lung cancer: Yes/No

j. Broken ribs: Yes/No

k. Any chest injuries or surgeries: Yes/No

l. Any other lung problem that you've been told about: Yes/No

4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?

a. Shortness of breath: Yes/No

b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No

c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No

d. Have to stop for breath when walking at your own pace on level ground: Yes/No

e. Shortness of breath when washing or dressing yourself: Yes/No

f. Shortness of breath that interferes with your job: Yes/No

g. Coughing that produces phlegm (thick sputum): Yes/No

h. Coughing that wakes you early in the morning: Yes/No

i. Coughing that occurs mostly when you are lying down: Yes/No

j. Coughing up blood in the last month: Yes/No

k. Wheezing: Yes/No

l. Wheezing that interferes with your job: Yes/No

m. Chest pain when you breathe deeply: Yes/No

n. Any other symptoms that you think may be related to lung problems: Yes/No

5. Have you *ever had* any of the following cardiovascular or heart problems?

a. Heart attack: Yes/No

b. Stroke: Yes/No

c. Angina: Yes/No

d. Heart failure: Yes/No

e. Swelling in your legs or feet (not caused by walking): Yes/No

f. Heart arrhythmia (heart beating irregularly): Yes/No

g. High blood pressure: Yes/No

h. Any other heart problem that you've been told about: Yes/No

6. Have you *ever had* any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest: Yes/No

b. Pain or tightness in your chest during physical activity: Yes/No

c. Pain or tightness in your chest that interferes with your job: Yes/No

d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No

e. Heartburn or indigestion that is not related to eating: Yes/No

d. Any other symptoms that you think may be related to heart or circulation problems: Yes/No

7. Do you *currently* take medication for any of the following problems?

a. Breathing or lung problems: Yes/No

b. Heart trouble: Yes/No

c. Blood pressure: Yes/No

d. Seizures: Yes/No

8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check the following space and go to question 9:)

a. Eye irritation: Yes/No

b. Skin allergies or rashes: Yes/No

c. Anxiety: Yes/No

d. General weakness or fatigue: Yes/No

e. Any other problem that interferes with your use of a respirator: Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you *ever lost* vision in either eye (temporarily or permanently): Yes/No

11. Do you *currently* have any of the following vision problems?

a. Wear contact lenses: Yes/No

b. Wear glasses: Yes/No

c. Color blind: Yes/No

d. Any other eye or vision problem: Yes/No

12. Have you *ever had* an injury to your ears, including a broken ear drum: Yes/No

13. Do you *currently* have any of the following hearing problems?

a. Difficulty hearing: Yes/No

b. Wear a hearing aid: Yes/No

c. Any other hearing or ear problem: Yes/No

14. Have you *ever had* a back injury: Yes/No

15. Do you *currently* have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet: Yes/No

b. Back pain: Yes/No

c. Difficulty fully moving your arms and legs: Yes/No

d. Pain or stiffness when you lean forward or backward at the waist: Yes/No

e. Difficulty fully moving your head up or down: Yes/No

f. Difficulty fully moving your head side to side: Yes/No

g. Difficulty bending at your knees: Yes/No

h. Difficulty squatting to the ground: Yes/No

i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No

j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes/No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes/No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No

If "yes," name the chemicals if you know them:_____

_____

_____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

a. Asbestos: Yes/No

b. Silica (*e.g.*, in sandblasting): Yes/No

c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No

d. Beryllium: Yes/No

e. Aluminum: Yes/No

f. Coal (for example, mining): Yes/No

g. Iron: Yes/No

h. Tin: Yes/No

i. Dusty environments: Yes/No

j. Any other hazardous exposures: Yes/No

If "yes," describe these exposures:_____
_____
_____

4. List any second jobs or side businesses you have:_____
_____

5. List your previous occupations:_____
_____

6. List your current and previous hobbies:_____
_____

7. Have you been in the military services? Yes/No

If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/No

8. Have you ever worked on a HAZMAT team? Yes/No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes/No

If "yes," name the medications if you know them:_____

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters: Yes/No

b. Canisters (for example, gas masks): Yes/No

c. Cartridges: Yes/No

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:

a. Escape only (no rescue): Yes/No

b. Emergency rescue only: Yes/No

c. Less than 5 hours *per week:* Yes/No

d. Less than 2 hours *per day:* Yes/No

e. 2 to 4 hours per day: Yes/No

f. Over 4 hours per day: Yes/No

12. During the period you are using the respirator(s), is your work effort:

a. *Light* (less than 200 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of a light work effort are *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines.

b. *Moderate* (200 to 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5-degree grade about 3 mph; or *pushing*a wheelbarrow with a heavy load (about 100 lbs.) on a level surface. c. *Heavy* (above 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of heavy work are *lifting* a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; *shoveling; standing* while bricklaying or chipping castings; *walking* up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No

If "yes," describe this protective clothing and/or equipment:_____

_____

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes/No

15. Will you be working under humid conditions: Yes/No

16. Describe the work you'll be doing while you're using your respirator(s):

_____

_____

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

_____

_____

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
Name of the second toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
Name of the third toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
The name of any other toxic substances that you'll be exposed to while using your respirator:

_____

_____

_____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

_____

_____

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998; 76 FR 33607, June 8, 2011; 77 FR 46949, Aug. 7, 2012]

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# RESPIRATOR FITNESS / MEDICAL CLEARANCE

Employee Name: _____ SS#: ____/____/____

Company: _____

☐ Medically Fit and Approved for All Respirator Use under any working Conditions

☐ Limited Respirator Use Only:

_____

_____

_____

☐ Not approved for negative pressure respirator but may use a Powered Air-Purifying Respirator (PAPR).

Recommendations including re-evaluation:

_____

_____

_____

☐ Not Medically Fit for Respirator Use

☐ A copy of this form has been given to the employee.

Licensed Healthcare Professional Signature: _____ Date: _____

Licensed Healthcare Professional Name: _____

_____

| | | |
|---|---|---|
| ☐ HealthWorks Allentown | 1243 S. Cedar Crest Blvd, Allentown, PA 18103 | 610-402-9230 |
| ☐ HealthWorks Trexlertown | 6900 Hamilton Blvd, Trexlertown, PA 18087 | 610-402-0047 |
| ☐ HealthWorks Bethlehem | 1770 Bathgate Rd, Bethlehem, PA 18017 | 484-884-2249 |
| ☐ HealthWorks Easton | 2101 Emrick Boulevard, Bethlehem, PA 18020 | 610-866-9675 |

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# 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