



**PRE-PLACEMENT  
PEACE OFFICER**

**MEDICAL HISTORY STATEMENT  
AND MEDICAL EXAMINATION REPORT**

**Applicant instructions:**

1. Complete the Medical History Statement that begins on the next page. The information you provide in this questionnaire is extremely important. It will be used by a physician to advise the County of your ability to perform the essential functions of the position you applied for safely, with or without restrictions. Please fill out the questionnaire completely and accurately.
2. Complete the starred (\*) information on Page 11 of the packet.

The [Genetic Information Nondiscrimination Act of 2008](#) (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

**Instructions:**

- Fill out the questionnaire completely and accurately. Keep in mind that all statements are subject to verification; deliberate inaccuracies or incomplete statements may bar or remove you from employment. A "yes" answer does not necessarily mean that you will be disqualified.
- This form must be completed and presented when reporting for your medical examination.
- This medical history statement is confidential. If hired, the information you provide will be part of your medical record, separate from your personnel file.
- Type or legibly print (in ink), or complete this form online at [www.post.ca.gov/forms.aspx](http://www.post.ca.gov/forms.aspx).

**SECTION 1. CANDIDATE IDENTIFICATION**

1. CANDIDATE'S NAME (Last, First, Middle)		2. SOCIAL SECURITY NUMBER	3. BIRTHDATE (MM/DD/YYYY)
		Last 4 digits:	
4. ADDRESS WHERE YOU CAN BE CONTACTED (Street / P.O. Box)		5. CITY	6. STATE / ZIP
7. PHONE NUMBERS WHERE YOU CAN BE REACHED		8. EMAIL	
Day: (    )    -    Evening: (    )    -			

**SECTION 2: JOB HISTORY AND PHYSICAL ACTIVITY**

9. List current and all previous jobs held in the last 5 years, including military service.

JOB TITLE	PRIMARY DUTIES	EMPLOYER	APPROXIMATE DATES
A)			From: To:
B)			From: To:
C)			From: To:
D)			From: To:
E)			From: To:
F)			From: To:
G)			From: To:
H)			From: To:
I)			From: To:

10. Describe your typical physical activity, including that at work. Indicate how often and how long you've been doing it.

	EXERCISE / ACTIVITY	HRS PER WK	HOW LONG?
A)			yrs    mos
B)			yrs    mos
C)			yrs    mos

# MEDICAL HISTORY STATEMENT – Peace Officer

POST 2-252 (Rev 02/2013)

## SECTION 3: MEDICAL HISTORY

Y	N	?	Answer each of the following questions.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever worked as a peace officer before?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever failed to complete a peace officer academy training program?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever failed a pre-placement medical or psychological examination?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Have you ever been refused employment or been unable to hold a job because of any physical, psychological, or other medically-related reason?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever been terminated or resigned from employment, or had to change job positions due to a physical, psychological, or medically-related reason?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Are you currently under a health care provider's care for any medical condition?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Has your driver's license ever been suspended or revoked due to medical reasons?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. Do you have any physical limitations?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Do you need any reasonable accommodation to assist you in performing required job tasks?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Have you ever been absent from work due to job stress?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Have you missed more than five days from work in the past 12 months due to medically-related reasons?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22. Have you ever been absent from work because of back/neck pain or problems?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. Have you ever seen a doctor for back/neck pain or problems?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you currently have a cold or cough, or have you had either in the past two weeks?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. In the past year, have you had a change in the size and color of a mole or a sore that would not heal?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever coughed, or wheezed, or had chest discomfort during or after exercise?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Have you ever taken medication to prevent wheezing or shortness of breath during exercise?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. Do you ever wake up short of breath?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29. Have you ever had any breathing problems using a gas mask? (Check "No" if you have never used a gas mask.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30. Do you currently smoke cigarettes? IF YES: How many packs per day? ____ For how long (in years)? ____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31. Are you an ex-smoker? IF YES: How many years did you smoke? ____ Packs per day? ____ Approx date quit: _____ (MM/YYYY)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32. Have you used chewing tobacco or smoked cigars/pipes in the last 15 years?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you ever had a positive drug or alcohol test?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34. Are you now or have you ever been enrolled in a drug or alcohol rehabilitation program?
			35. Per week, I drink: ____ bottles/cans of beer ____ glasses of wine ____ glasses of hard liquor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	36. Has anyone ever been concerned about your drinking or suggested that you cut down?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37. Have you ever been convicted of driving under the influence (DUI)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38. Have you ever felt bad about your drinking?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
			40. I am: <input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41. Have you ever been hospitalized overnight (except for pregnancy)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42. Have you had any surgical operations?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43. Have you sustained any disabling illnesses or medical conditions within the past 5 years?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44. Have you been exposed to loud noise today? IF YES: Were you wearing hearing protection? <input type="checkbox"/> Yes <input type="checkbox"/> No



# MEDICAL HISTORY STATEMENT – Peace Officer

POST 2-252 (Rev 02/2013)

## SECTION 4: MEDICAL CONDITIONS Indicate if you have, or ever had, any of the following conditions. If you're unsure, mark "?"

Indicate if you have, or ever had, any of the following conditions. If you're unsure, mark "?"

	Y	N	?		Y	N	?		Y	N	?
<b>51. EYE, EAR, NOSE, THROAT</b>											
A) Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H) Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O) Ringing or buzzing in ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Refractive surgery (e.g., Lasik, PRK)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I) Blurred or double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P) Hearing trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Orthokeratology / Retainer lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	J) Abnormal color vision test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Q) Ear surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) Vision therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	K) Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R) Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E) Vision impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L) Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	S) Abnormal hearing test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F) Need to wear corrective lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M) Allergy / Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
G) Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N) Ruptured ear drum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>52. RESPIRATORY</b>											
A) Asthma (age at last episode: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D) Positive TB skin test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G) Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E) Coughed up blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H) Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Chronic or frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I) Blood clot in lung	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>53. GASTROINTESTINAL</b>											
A) Ulcer / Stomach trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Gall bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	K) Abnormal liver test / Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Vomited blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G) Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L) Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Persistent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H) Mucous in stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M) Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I) Black/bloody bowel movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N) Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E) Recurrent hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	J) Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>54. GENITOURINARY</b>											
A) Kidney disease or stone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D) Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G) Menstrual discomfort that kept you from work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E) Prostatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H) Currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Irregular vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>55. CARDIOVASCULAR</b>											
A) Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E) Enlarged heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I) Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Palpitation (irregular heartbeat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	J) Swelling of foot or leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G) High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	K) Painful varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) Heart valve abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H) Pain or discomfort in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>56. MUSCULOSKELETAL</b>											
A) Fractured/broken bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C) Neck trouble/pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E) Arthroscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Back trouble/pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D) Leg/shin pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Arthritis / Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>57. JOINT INJURY / SURGERY / DISLOCATION / PAIN / SWELLING</b>											
A) Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D) Fingers/toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G) Ankle/foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E) Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H) Other joint pain or swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				





**SECTION 1. EXAMINATION FINDINGS**

1. CANDIDATE'S NAME (LAST, FIRST, MI)	2. BIRTH DATE (MM/DD/YYYY)
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3. SOCIAL SECURITY NUMBER Last 4 digits:	4. SEX <input type="checkbox"/> M <input type="checkbox"/> F	5. HEIGHT Without shoes: FT INCHES	6. WEIGHT Without shoes and coat: LBS
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7. VISION					8. BLOOD PRESSURE		9. HEARING TEST		10. RETEST				
	UNCORRECTED		CORRECTED		<input type="checkbox"/> GLASSES <input type="checkbox"/> CONTACTS PERIPHERAL VISION: COLOR VISION: OTHER VISION TESTS:				Left	Right		Left	Right
	Far	Near	Far	Near					500	1000		2000	3000
Right					Initial test BP after 3–5 min in chair: ___ / ___ Pulse: ___  Repeat if BP>120/80: ___ / ___ Pulse: ___  Third test if 1 <sup>st</sup> & 2 <sup>nd</sup> reads differ by >5 mm Hg: ___ / ___ Pulse: ___								
Left													
Both													

11. For each of the following conditions, indicate **Normal**, **Abnormal**, or **Not Examined** and include additional findings as needed.

CHECKLIST	NORM	AB	NE	DESCRIBE ANY ABNORMAL FINDINGS AND/OR SUPPLEMENTAL TESTS
<b>A) SKIN</b>				
Color / Texture – Lesions, scars, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tattoos – Racist, gang-related, removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B) HEAD / EYES</b>				
Corneas (RK scars)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pupils / Light reaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fundi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
EOM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C) EARS / NOSE / THROAT / MOUTH</b>				
Pinna / Canals / TM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nasal septum / Mucosa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Teeth / Gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tongue / Palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>D) NECK</b>				
Bruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ROM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cervical nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
C5-C7 sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Palpation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



# MEDICAL EXAMINATION REPORT – Peace Officer

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## SECTION 1. EXAMINATION FINDINGS *continued*

CHECKLIST	NORM	AB	NE	DESCRIBE ANY ABNORMAL FINDINGS AND/OR SUPPLEMENTAL TESTS
<b>E) ABDOMEN</b>				
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel sounds (Bruit)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Liver / Kidney / Spleen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Masses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>F) CARDIOVASCULAR</b>				
Pulses: Radial / Femoral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pulses: D. Pedis / P. Tibial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Apex impulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart sounds (murmurs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart rate and rhythm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>G) CHEST / LUNGS</b>				
Auscultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Breasts – Females age 50 and over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Axillary nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chest wall expansion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>H) MUSCULOSKELETAL</b>				
UPPER EXTREMITY:				
• Shoulder ROM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Shoulder strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Wrists / Fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Shoulder Apprehension Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Grip strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BACK:				
• Inspection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Palpation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Heel / Toe walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Flexion / Extension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Passive SLR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• L3-S1 sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

# MEDICAL EXAMINATION REPORT – Peace Officer

POST 2-253 (Rev 04/2018)

## SECTION 1. EXAMINATION FINDINGS *continued*

CHECKLIST	NORM	AB	NE	DESCRIBE ANY ABNORMAL FINDINGS AND/OR SUPPLEMENTAL TESTS
<b>H) MUSCULOSKELETAL</b> <i>continued</i>				
KNEES:				
· Inspection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Patellar apprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Duck-walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Thigh circumference	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Lachman Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Collateral stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· One-leg hop for distance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Anterior / Posterior drawer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
· Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>I) NERVOUS SYSTEM</b>				
Tremor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reflexes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>J) GENITALIA / RECTAL – NOTE: Recent exam and test results from candidate's private physician are permissible.</b>				
Rectal – Age 50 and over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Inguinal Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Male: Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Female: Pap smear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>K) LABORATORY FINDINGS</b>				
CBC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chem. Panel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urinalysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ECG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Spirometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mammogram – Age 50 and over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sigmoidoscopy – Age 50 and over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PPD Mantoux – If assigned to prisons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CXR – Smokers age 40 and over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



**SECTION 2. SUITABILITY DECLARATION – to be maintained in the background investigation file**

**Instructions to the Physician:**

- Pages 11 and 12 to be completed and submitted to OHP at (213) 784-1713
- OHP will maintain this Medical Suitability Declaration page in the individual’s background investigation file. **Do not include medical information on pages 11 and 12.**

**Medical Suitability Declaration**

Candidate’s Name\* \_\_\_\_\_

Birth Date\* \_\_\_\_\_ Last 4 digits of Social Security Number\* \_\_\_\_\_

Street Address\* \_\_\_\_\_ City\* \_\_\_\_\_ State\* \_\_\_\_\_ Zip\* \_\_\_\_\_

Email Address\* \_\_\_\_\_

Applicant seen at:  Westchester  Glendale  Irwindale

On \_\_\_\_\_, I completed a pre-employment medical screening evaluation  
[DATE OF EVALUATION]

on the above-named peace officer candidate, in accordance with POST Commission [Regulation 1954](#). Based on the results and findings of that evaluation:

**I certify** that the candidate is medically suitable to perform the peace officer duties and responsibilities as defined and provided by the hiring department either without any accommodations, or provided that the specified work restrictions, limitations, or reasonable accommodations can be implemented. *(Describe any work restrictions, limitations, or reasonable accommodation requirements on the supplemental medical information page.)*

**I cannot certify** that the candidate is medically suitable to perform the peace officer duties and responsibilities as defined and provided by the hiring department.

Physician’s Signature ► \_\_\_\_\_

Physician’s Printed Name,  
Medical License Number,  
and Contact Information:

