COUNTY OF LOS ANGELES



Department of Human Resources | Occupational Health Programs Pre-Employment/Post-Offer Medical Examinations Phone: 213-738-2187 | Fax: 213-784-1713

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.

SECTION 1. CANDIDATE IDENTIFICATION

1. CANDIDATE'S NAME (Last, First, Middle)

MEDICAL HISTORY STATEMENT – Peace Officer

POST 2-252 (Rev 02/2013)

Commission on Peace Officer Standards and Training (**POST**) 860 Stillwater Road, Suite 100 West Sacramento, CA 95605-1630

3. BIRTHDATE (MM/DD/YYYY)

HRS PER WK

HOW LONG?

mos

mos

mos

yrs

yrs

yrs

2. SOCIAL SECURITY NUMBER

Last 4 digits:

The <u>Genetic Information Nondiscrimination Act of 2008</u> (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 or an individual or family member received genetic services, and genetic information of a fetus carried by an individual or 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 <u>www.post.ca.gov/forms.aspx</u>.

4. ADDRESS WH	IERE YOU CAN BE CONTA	ACTED (Street / P.O. Box)		5. CITY		6. STATE / ZIP
7. PHONE NUMB	ERS WHERE YOU CAN B	E REACHED		8. EMAIL		
Day: () –	Evening: () -			
SECTION 2:	JOB HISTORY A	ND PHYSICAL ACTIV	'ITY			
9. List curre	nt and all previous j	obs held in the last 5	years, including military ser	vice.		
J	OB TITLE	PRI	MARY DUTIES		EMPLOYER	APPROXIMATE DATES
A)						From:
						To:
B)						From:
						To:
C)						From:
						То:
D)						From:
1						То:
E)						From:
						To:
F)						From:
						To:
G)						From:
						To:
H)						From:
						То:
l)						From:
						To:
10. Describe	your typical physica	al activity, including tha	at at work. Indicate how often	en and how long you	've been doing it.	

EXERCISE / ACTIVITY

A)

B)

C)

SEC	TION	3: M	EDICAL HISTORY									
Υ	N	?	Answer each of the following questions.									
			11. Have you ever worked as a peace officer before?									
			12. Have you ever failed to complete a peace officer academy training program?									
			e you ever failed a pre-placement medical or psychological examination?									
			14. Have you ever been refused employment or been unable to hold a job because of any physical, psychological, or other medically-related reason?									
			Have you ever been terminated or resigned from employment, or had to change job positions due to a physical, psychological, or medically-related reason?									
			16. Are you currently under a health care provider's care for any medical condition?									
			17. Has your driver's license ever been suspended or revoked due to medical reasons?									
			18. Do you have any physical limitations?									
			19. Do you need any reasonable accommodation to assist you in performing required job tasks?									
			20. Have you ever been absent from work due to job stress?									
			21. Have you missed more than five days from work in the past 12 months due to medically-related reasons?									
			22. Have you ever been absent from work because of back/neck pain or problems?									
			23. Have you ever seen a doctor for back/neck pain or problems?									
			24. Do you currently have a cold or cough, or have you had either in the past two weeks?									
			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?									
			26. Have you ever coughed, or wheezed, or had chest discomfort during or after exercise?									
			27. Have you ever taken medication to prevent wheezing or shortness of breath during exercise?									
			28. Do you ever wake up short of breath?									
			29. Have you ever had any breathing problems using a gas mask? (Check "No" if you have never used a gas mask.)									
			30. Do you currently smoke cigarettes? IF YES: How many packs per day? For how long (in years)?									
			31. Are you an ex-smoker? IF YES: How many years did you smoke? Packs per day? Approx date quit: (MM/YYYY)									
			32. Have you used chewing tobacco or smoked cigars/pipes in the last 15 years?									
			33. Have you ever had a positive drug or alcohol test?									
			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									
			36. Has anyone ever been concerned about your drinking or suggested that you cut down?									
			37. Have you ever been convicted of driving under the influence (DUI)?									
			38. Have you ever felt bad about your drinking?									
			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: Right-handed Left-handed									
			41. Have you ever been hospitalized overnight (except for pregnancy)?									
			42. Have you had any surgical operations?									
			43. Have you sustained any disabling illnesses or medical conditions within the past 5 years?									
			44. Have you been exposed to loud noise today? IF YES: Were you wearing hearing protection?									

		·	<u> </u>
SEC	TION	3: M	EDICAL HISTORY
Υ	N	?	Answer each of the following questions.
			45. Do you occasionally use, or are you currently taking, any prescription or over-the-counter medications?
			46. Have you taken any medication within the past 12 months for any reason?
			47. Are you now receiving or have you ever received Workers Compensation?
			48. Have you been rejected for, or discharged from the military because of, physical, mental, or other medically-related reasons?
			49. If you served in the military and were discharged, did you ever apply to the Veteran's Administration (VA) for service-connected disability for medical injuries?
			If YES, what percent disability classification do/did you have?%
			For what kind of medical injury was the award granted? Provide details:
50.	Briefly suitab	expl	ain any items you marked "yes" or "?." In addition, describe anything else which you feel may be important in evaluating your medical or the position, including any condition(s) not specifically referred to in the preceding questions.
ITE	M #		EXPLANATION – USE ADDITIONAL SHEETS IF NECESSARY

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 t	he fo	llowi	ng conditions. If you're unsure, mark	"?"						
	Υ	N	?		Υ	N	?		Υ	N	?
51. EYE, EAR, NOSE, THROAT	ı	ı	1		I	I	l I		1		
A) Eye surgery				H) Glaucoma				O) Ringing or buzzing in ears			
B) Refractive surgery (e.g., Lasik, PRK)				I) Blurred or double vision				P) Hearing trouble			
C) Orthokeratology / Retainer lenses				J) Abnormal color vision test				Q) Ear surgery			
D) Vision therapy				K) Sinus trouble				R) Earache			
E) Vision impairment				L) Loss of smell				S) Abnormal hearing test			
F) Need to wear corrective lenses				M) Allergy / Hay fever							
G) Cataracts				N) Ruptured ear drum							
52. RESPIRATORY											
A) Asthma (age at last episode:)				D) Positive TB skin test				G) Chest tightness			
B) Shortness of breath				E) Coughed up blood				H) Wheezing			
C) Chronic or frequent cough				F) Pneumothorax (collapsed lung)				I) Blood clot in lung			
53. GASTROINTESTINAL											
A) Ulcer / Stomach trouble				F) Gall bladder trouble				K) Abnormal liver test / Liver disease			
B) Vomited blood				G) Hepatitis				L) Hernia			
C) Persistent diarrhea				H) Mucous in stool				M) Irritable Bowel Syndrome			
D) Colitis				Black/bloody bowel movement				N) Crohn's disease			
E) Recurrent hemorrhoids				J) Pancreatitis							
54. GENITOURINARY											
A) Kidney disease or stone				D) Blood in urine				G) Menstrual discomfort that kept you from work			
B) Bladder trouble				E) Prostatitis				H) Currently pregnant			
C) Difficulty urinating				F) Irregular vaginal bleeding							
55. CARDIOVASCULAR			_			_					
A) Heart attack				E) Enlarged heart				I) Rheumatic fever			
B) Heart murmur				F) Palpitation (irregular heartbeat)				J) Swelling of foot or leg			
C) Heart failure				G) High blood pressure				K) Painful varicose veins			
D) Heart valve abnormality				H) Pain or discomfort in chest							
56. MUSCULOSKELETAL											
A) Fractured/broken bone				C) Neck trouble/pain				E) Arthroscopy			
B) Back trouble/pain				D) Leg/shin pain				F) Arthritis / Rheumatism			
57. JOINT INJURY / SURGERY / DIS	LOC	ATIC	ON / I	PAIN / SWELLING							
A) Shoulder				D) Fingers/toes				G) Ankle/foot			
B) Elbow				E) Hip				H) Other joint pain or swelling			
C) Wrist				F) Knee							

SECTION 4: MEDICAL CONDITIONS continued												
Indicate if you have, or ever had, any	of t	he fo	ollowi	ing co	onditions. If you're unsure, mark	"?"						
	Υ	N	?			Υ	N	?		Υ	N	?
58. NEUROLOGICAL			I — I			I				_1		
A) Epilepsy					Head injury				K) Skull defect			
B) Convulsion / Seizure				G)	Loss of consciousness				L) Tremors			
C) Fainting spells / Blackouts				H)	Frequent/recurrent headaches				M) Meningitis / Encephalitis	\rightarrow		
D) Recurrent dizziness				I)	Migraine/sinus headaches				N) Numbness of extremities			
E) Carpal Tunnel Syndrome				J)	Multiple Sclerosis				O) Other			
59. MISCELLANEOUS			1 1			ı	I					1
A) Diabetes				I)	Cancer / Leukemia				Q) Recurrent fever in the last year			
B) Low blood sugar				J)	Wool allergy				R) Eczema			
C) Thyroid trouble				K)	Non-healing sores				S) Claustrophobia			
D) Bleeding tendencies				L)	Chronic fatigue				T) Sleep apnea			
E) Anemia				M)	Night sweats				U) Snoring			
F) Enlarged glands				N)	Undesired weight loss or gain				V) Sleep problems/disorders			
G) Cyst / Tumor				O)	Heat stress				W) Any other problem or illness not listed that may affect job performance			
H) Skin problems / Rashes				P)	Multiple chemical sensitivity							
60. Explain any medical conditions yo	u m	arke	ed "ve	es" or	"?." Reference the correspondi	na it	em r	umb	er and letter in your response (52B, 5	7F. e	etc.)).
ITEM#					EXPLANATION - USE ADDITIONAL S					•		,

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SECTION 5: CANDIDATE CONSENT

I hereby authorize the performance of a complete medical examination, x-rays, blood testing, and urine testing. I am aware that laboratory testing may be used to detect illegal substances and therapeutic medications, and to verify my answers to the questions contained in this medical questionnaire. I also authorize the medical examiner to obtain current or past medical records and to discuss my medical status and history with my treating physician or other medical consultants as necessary. I declare that my answers are true to the best of my knowledge and belief. I am aware that any willful inaccuracy may be regarded as cause for disqualification for employment.

SIGNATUR	E IN FULL		DATE
•			
SECTIO	N 6: EXAMINING PHYSICIAN'S COMMENTS / NOTES		
ITEM#		COMMENTS / NOTES	

MEDICAL EXAMINATION REPORT – Peace Officer

POST 2-253 (Rev 04/2018)

Commission on Peace Officer Standards and Training (**POST**) 860 Stillwater Road, Suite 100 West Sacramento, CA 95605-1630

	TION 1. EX			DING	S										2. BIRTH I	DATE (M	M/DD/YY	YY)
-																		
	IAL SECURITY t 4 digits:	NUMBER				4. SEX	х] М	□F		HEIGHT ithout shoes:	FT	INCHES	6. WE		s and coa	nt:	LBS	
7. VISIO											1	OOD PRESSURE		RING TE		10. RE		
	UNCOR	RECTED	COF	RECTE	D	GL	ASSES	CON1	TACTS	PERIPHERAL	Initial			Left	Right		Left	Right
	Far	Near	Far	N	lear	COLO	R VISIOI	N:		VISION:		fter 3–5 min in chair: / Pulse:	500			500		
Right								N TESTS:		Right	Repe	eat if BP>120/80:	1000 2000			1000 2000		
												/ Pulse:	3000			3000		
Left										Left		test if 1 st & 2 nd reads by >5 mm Hg:	4000			4000		
Both										•	·	/ Pulse:	6000			6000		
44 FO	r oach of th	o followin	a conditio	ne in	dicato	Norma	al Abr	ormal	or Not	Evamined and	include	e additional finding	8000	oodod		8000		
11. 1-01		KLIST	y condition	NORM		NE	ai, Abi	iorinai,				L FINDINGS AND			ENTAL T	ESTS		
A) SK																		
	olor / Textur Lesions, sca																	
	ttoos Racist, gang	g-related, r	emoval															
	her																	
B) HE	AD / EYES	3																
Co	rneas (RK	scars)																
Pu	ıpils / Light	reaction																
Fu	ndi																	
EC	OM																	
Ot	her																	
C) EA	RS / NOS	E / THRO	AT / MOU	JTH														
Pir	nna / Canal	s / TM																
Na	isal septum	ı / Mucosa	ı															
Те	eth / Gums	•																
То	ngue / Pala	ate																
Ot	her																	
D) NE	CK				ı	1												
Br	uit																	
RO	OM																	
Th	yroid																	
Се	ervical node	es																
C5	5-C7 senso	ry																
Pa	Ilpation																	
Ot	her																	

MEDICAL EXAMINATION REPORT – Peace Officer

POST 2-253 (Rev 04/2018)

SECTION 1. EXAMINATION FI	NDING	S cont	inued	
CHECKLIST	NORM	AB	NE	DESCRIBE ANY ABNORMAL FINDINGS AND/OR SUPPLEMENTAL TESTS
E) ABDOMEN				
Hernia				
Bowel sounds (Bruits)				
Liver / Kidney / Spleen				
Masses				
Other				
F) CARDIOVASCULAR				
Pulses: Radial / Femoral				
Pulses: D. Pedis / P. Tibial				
Apex impulse				
Heart sounds (murmurs)				
Heart rate and rhythm				
Other				
G) CHEST / LUNGS			J	
Auscultation				
Breasts – Females age 50 and over				
Axillary nodes				
Chest wall expansion				
Other				
H) MUSCULOSKELETAL				
UPPER EXTREMITY:		ı	1	
· Shoulder ROM				
Shoulder strength				
· Wrists / Fingers				
· Shoulder Apprehension Test				
· Grip strength				
· Other				
BACK:	_	!	1	
· Inspection				
· Palpation				
· Heel / Toe walk				
Flexion / Extension				
· Passive SLR				
· L3-S1 sensory				
· Other				

MEDICAL EXAMINATION REPORT - Peace Officer

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SECTION 1. EXAMINATION FIN	DING	S conti	inued	
CHECKLIST	NORM	AB	NE	DESCRIBE ANY ABNORMAL FINDINGS AND/OR SUPPLEMENTAL TESTS
H) MUSCULOSKELETAL continued KNEES:	1			
· Inspection				
· Patellar apprehension				
· Squat				
· Duck-walk				
· Thigh circumference				
· Lachman Test				
· Collateral stability				
· One-leg hop for distance				
· Anterior / Posterior drawer				
· Other				
I) NERVOUS SYSTEM				
Tremor				
Reflexes				
Gait				
Other				
	Recei	nt exa	m and	test results from candidate's private physician are permissible.
Rectal - Age 50 and over				
Inguinal Hernia				
Male: Genitalia				
Female: Pap smear				
Other				
K) LABORATORY FINDINGS		1		
CBC				
Chem. Panel				
Urinalysis				
ECG				
Spirometry				
Mammogram – Age 50 and over				
Sigmoidoscopy – Age 50 and over				
PPD Mantoux – If assigned to prisons				
CXR – Smokers age 40 and over				
Other				

MEDICAL EXAMINATION REPORT - Peace Officer

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= e.		
ES:		
URE OF LICENSED EXAMINING PHYSICIAN	PRINT PHYSICIAN'S NAME	DATE
SS OF PRACTICE (Street, City, State, Zip)		PHONE:

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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]	ition
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 responsit as defined and provided by the hiring department either without any accommodations, or provide that the specified work restrictions, limitations, or reasonable accommodations can be implement (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. 	d
Physician's Signature	
Physician's Printed Name, Medical License Number, and Contact Information:	

MEDICAL EXAMINATION REPORT – Peace Officer

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Return page 11 and 12 only to OHP via fax at (213) 784-1713

SECTION 3. SUPPLEMENTAL MEDICAL INFORMATION - to be maintained in a separate *confidential* medical file Instructions to the Physician:

Provide any additional information to the hiring department regarding the candidate's job-relevant **functional limitations**, **reasonable accommodation requirements**, **work restrictions**, and/or a description of the **nature and degree of potential risks** posed by the detected medical conditions. Include that information which is necessary and appropriate for the hiring department in making a hiring decision.

To the Hiring Department:

To the Hiring Department:		
This page should be maintained in a <i>confidential medical</i> Access to the information on this page should be limited to supervisors).		
Candidate's Name	Birth Date	Last 4 Digits of SSN
Examining Physician's Name (<i>please print</i>)		Report Date