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
PUBLIC SAFETY DISPATCHER

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 7 of the packet.

CLEAR PAGE 1 PRINT FORM

State of California – Department of Justice

MEDICAL HISTORY STATEMENT – Public Safety Dispatcher

POST 2-264 (Rev 02/2013)

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

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.

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

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:

SECTION 3. MEDICAL HISTORY

Y	N	?	Answer each of the following questions.
☐	☐	☐	10. Have you ever worked as a public safety dispatcher before?
☐	☐	☐	11. Have you ever failed to complete a public safety dispatcher training program?
☐	☐	☐	12. Have you ever failed a pre-placement medical examination?
☐	☐	☐	13. Have you ever been refused employment or been unable to hold a job because of any physical, psychological, or other medically-related reason?
☐	☐	☐	14. Are you currently under a health care provider's care for any medical condition?
☐	☐	☐	15. Do you have any physical limitations?

MEDICAL HISTORY STATEMENT – Public Safety Dispatcher

POST 2-264 (Rev 02/2013)

CLEAR PAGE 2

SECTION 3. MEDICAL HISTORY *continued*

Y	N	?	Answer each of the following questions.
☐	☐	☐	16. Do you need any reasonable accommodation to assist you in performing required job tasks?
☐	☐	☐	17. Have you ever been absent from work due to job stress?
☐	☐	☐	18. Have you missed more than five days from work in the past 12 months due to medically-related reasons?
☐	☐	☐	19. Have you ever been absent from work because of back/neck pain or problems?
☐	☐	☐	20. Have you ever seen a doctor for back/neck pain or problems?
☐	☐	☐	21. In the past year, have you had a change in the size and color of a mole or a sore that would not heal?
☐	☐	☐	22. Do you occasionally use, or are you currently taking, any prescription or over-the-counter medications?
☐	☐	☐	23. Have you taken any medications within the past 12 months for any reason?
☐	☐	☐	24. Have you sustained any disabling illnesses or medical conditions with the past 5 years?
☐	☐	☐	25. Have you ever had a positive drug or alcohol test?
☐	☐	☐	26. Are you now or have you ever been enrolled in a drug or alcohol rehabilitation program?
☐	☐	☐	27. Per week, I drink: ____ bottles/cans of beer ____ glasses of wine ____ glasses of hard liquor
☐	☐	☐	28. Has anyone ever been concerned about your drinking or suggested that you cut down?
☐	☐	☐	29. Have you ever been convicted of driving under the influence (DUI)?
☐	☐	☐	30. Have you ever felt bad about your drinking?
☐	☐	☐	31. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
☐	☐	☐	32. Have you been exposed to loud noise today? If "yes," were you wearing hearing protection? ☐ Yes ☐ No
☐	☐	☐	33. Are you now receiving or have you ever received Workers Compensation?
☐	☐	☐	34. 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:*

35. Briefly explain any items you marked "yes" or "?." In addition, describe anything else which you feel may be important in evaluating your medical suitability for the position, including any condition(s) not specifically referred to in the preceding questions.

ITEM #	EXPLANATION – USE ADDITIONAL SHEETS IF NECESSARY

CLEAR PAGE 3

SECTION 4. MEDICAL CONDITIONS

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

	Y	N	?		Y	N	?		Y	N	?
36. EYE, EAR, NOSE, THROAT											
A) Eye surgery	☐	☐	☐	E) Abnormal color vision test	☐	☐	☐	I) Ear surgery	☐	☐	☐
B) Need to wear corrective lenses	☐	☐	☐	F) Refractive surgery (e.g., Lasik, PRK)	☐	☐	☐	J) Earache	☐	☐	☐
C) Blurred or double vision	☐	☐	☐	G) Ringing or buzzing in ears	☐	☐	☐	K) Abnormal hearing test	☐	☐	☐
D) Glaucoma	☐	☐	☐	H) Hearing trouble	☐	☐	☐				
37. GASTROINTESTINAL											
A) Ulcer / stomach trouble	☐	☐	☐	E) Mucous in stool	☐	☐	☐	I) Irritable bowel syndrome	☐	☐	☐
B) Persistent diarrhea	☐	☐	☐	F) Black / bloody bowel movement	☐	☐	☐	J) Crohn's disease	☐	☐	☐
C) Colitis	☐	☐	☐	G) Pancreatitis	☐	☐	☐				
D) Recurrent hemorrhoids	☐	☐	☐	H) Abnormal liver test / liver disease	☐	☐	☐				
38. GENITOURINARY											
A) Kidney disease or stone	☐	☐	☐	C) Blood in urine	☐	☐	☐	E) Menstrual discomfort that kept you from work	☐	☐	☐
B) Bladder trouble	☐	☐	☐	D) Prostatitis	☐	☐	☐	F) Currently pregnant	☐	☐	☐
39. CARDIOVASCULAR											
A) Heart attack	☐	☐	☐	C) Palpitation (irregular heartbeat)	☐	☐	☐	E) Pain or discomfort in chest	☐	☐	☐
B) Heart failure	☐	☐	☐	D) High blood pressure	☐	☐	☐	F) Swelling of foot or leg	☐	☐	☐
40. MUSCULOSKELETAL											
A) Back trouble/pain	☐	☐	☐	B) Neck trouble / Pain	☐	☐	☐	C) Arthritis / Rheumatism	☐	☐	☐
41. JOINT INJURY / SURGERY / DISLOCATION / PAIN / SWELLING											
A) Shoulder	☐	☐	☐	D) Fingers / Toes	☐	☐	☐	G) Ankle / Foot	☐	☐	☐
B) Elbow	☐	☐	☐	E) Hip	☐	☐	☐				
C) Wrist	☐	☐	☐	F) Knee	☐	☐	☐				
42. NEUROLOGICAL											
A) Epilepsy	☐	☐	☐	F) Head injury	☐	☐	☐	K) Tremors	☐	☐	☐
B) Convulsion / Seizure	☐	☐	☐	G) Loss of consciousness	☐	☐	☐	L) Meningitis / Encephalitis	☐	☐	☐
C) Fainting spells / Blackouts	☐	☐	☐	H) Frequent / recurrent headaches	☐	☐	☐	M) Numbness of extremities	☐	☐	☐
D) Multiple Sclerosis	☐	☐	☐	I) Migraine / Sinus headaches	☐	☐	☐	N) Other	☐	☐	☐
E) Recurrent dizziness	☐	☐	☐	J) Carpal Tunnel Syndrome	☐	☐	☐				
43. MISCELLANEOUS											
A) Diabetes (glucose in urine)	☐	☐	☐	G) Chronic fatigue	☐	☐	☐	M) Sleep apnea	☐	☐	☐
B) Low blood sugar	☐	☐	☐	H) Night sweats	☐	☐	☐	N) Snoring	☐	☐	☐
C) Thyroid trouble	☐	☐	☐	I) Undesired weight loss or gain	☐	☐	☐	O) Sleep problems / disorders	☐	☐	☐
D) Enlarged glands	☐	☐	☐	J) Multiple chemical sensitivity	☐	☐	☐	P) Chronic or frequent cough	☐	☐	☐
E) Cancer / Leukemia	☐	☐	☐	K) Recurrent fever in the last year	☐	☐	☐	Q) Any other problem or illness not listed that may affect job performance	☐	☐	☐
F) Non-healing sores	☐	☐	☐	L) Eczema	☐	☐	☐				

CLEAR PAGE 4

SECTION 4. MEDICAL CONDITIONS *continued*

44. Explain any medical conditions you marked "yes" or "?." Reference the corresponding item number and letter in your response (36B, 41F, etc.).

ITEM #	EXPLANATION – USE ADDITIONAL SHEETS IF NECESSARY

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.

SIGNATURE IN FULL	DATE
▶	

SECTION 6. EXAMINING PHYSICIAN S COMMENTS / NOTES

ITEM #	COMMENTS / NOTES

State of California – Department of Justice

MEDICAL EXAMINATION REPORT – Public Safety Dispatcher

POST 2-265 (Rev 04/2018)

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

SECTION 1. EXAMINATION FINDINGS

1. CANDIDATE'S NAME (LAST, FIRST, MI)

2. BIRTH DATE (MM/DD/YYYY)

3. SOCIAL SECURITY NUMBER
Last 4 digits:

4. SEX
☐ M ☐ F

5. HEIGHT
Without shoes: FT INCHES

6. WEIGHT
Without shoes and coat: LBS

7. VISION

	UNCORRECTED		CORRECTED	
	Far	Near	Far	Near
Right				
Left				
Both				

☐ GLASSES ☐ CONTACTS

COLOR VISION:

OTHER VISION TESTS:

PERIPHERAL VISION:

Right °

Left °

8. BLOOD PRESSURE

Initial test
BP after 3–5 min in chair: ___/___ Pulse: ___

Repeat if BP>120/80:
___/___ Pulse: ___

Third test if 1st & 2nd reads differ by >5 mm Hg:
___/___ Pulse: ___

9. HEARING TEST

	Left	Right
500		
1000		
2000		
3000		
4000		
6000		
8000		

10. RETEST

	Left	Right
500		
1000		
2000		
3000		
4000		
6000		
8000		

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
A) SKIN	☐	☐	☐	
	☐	☐	☐	
B) HEAD / EYES	☐	☐	☐	
	☐	☐	☐	
C) EARS / NOSE / THROAT / MOUTH	☐	☐	☐	
	☐	☐	☐	
D) CHEST / LUNGS	☐	☐	☐	
	☐	☐	☐	
E) ABDOMEN	☐	☐	☐	
	☐	☐	☐	
F) MUSCULOSKELETAL				
Upper Extremity	☐	☐	☐	
	☐	☐	☐	
Back / Neck	☐	☐	☐	
	☐	☐	☐	
Lower Extremity	☐	☐	☐	
	☐	☐	☐	
G) NERVOUS SYSTEM	☐	☐	☐	
	☐	☐	☐	
H) OTHER	☐	☐	☐	
	☐	☐	☐	
I) LABORATORY FINDINGS				
	☐	☐	☐	
	☐	☐	☐	

SECTION 1. EXAMINATION FINDINGS *continued*

NOTES:

SIGNATURE OF LICENSED EXAMINING PHYSICIAN ▶	PRINT PHYSICIAN'S NAME	DATE
ADDRESS OF PRACTICE (Street, City, State, Zip)		PHONE: ( )

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

Instructions to the Physician:

- Pages 7 and 8 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 7 and 8.**

Medical Suitability Declaration

Candidate's Name* _____

Birth Date* _____ Last 4 digits of Social Security Number* _____

Street Address* _____ City* _____ State* ____ Zip* _____

Email Address* _____ Phone* _____

Applicant seen at: ☐ Westchester ☐ Glendale ☐ Irwindale

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

the above-named public safety dispatcher candidate, in accordance with POST Commission Regulation 1960.

Based on the results and findings of that evaluation:

☐ **I certify** that the candidate is medically suitable to perform the public safety dispatcher 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 public safety dispatcher duties and responsibilities as defined and provided by the hiring department.

Physician's Signature ▶ _____

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

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:

This page should be maintained in a *confidential medical file*, separate from the candidate's background investigation file. Access to the information on this page should be limited to those who have a need to know (e.g., hiring authorities, supervisors).

Candidate's Name	**Birth Date**	**Last 4 Digits of SSN**

Examining Physician's Name (*please print*)	**Report Date**