

NOTE TO APPLICANT

1. Applicant must **LIVE IN OCONEE COUNTY.**
2. Applicant must attach an enlarged copy of driver's license to application.
3. Applicant must attach a copy of high school diploma or GED.
4. Applicant must be 18 years old to be officially on Oconee Fire - Rescue. We will review 17 year old applicants.
5. Application must be returned to the Fire Rescue Office by Applicant.
6. Applicant must attach a color photo to application or let office personnel take picture when returning application.

Pursuant to Title II ADA and Section 504 of the Rehabilitation Act of 1973, as amended, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by Oconee County, Georgia. Additionally, pursuant to Title VI of the Civil Rights Act of 1964 and the Civil Rights Restoration Act of 1987, no person shall on the grounds of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity conducted by Oconee County, Georgia.

OFFICE USE ONLY:
REC'D IN OFFICE _____
REQUIRED FORMS No Yes

OCONEE COUNTY FIRE - RESCUE APPLICATION

(CHECK WHAT YOU ARE MAKING APPLICATION FOR)

FIRE MEDICAL

Please print using blue or black ink only

FULL NAME: (Last) _____

(First) _____ (Middle) _____

Date of Birth: _____ Social Security No.: _____

Address: _____

Mailing Address: _____

Home Phone Number: _____

Mobile Phone Number: _____ E-Mail Address: _____

Briefly explain why you are applying for a position in Oconee County's Fire-Rescue Service:

How did you learn about volunteering with Oconee County Fire-Rescue:

Driver's License Number: _____ Class: _____ Status – Valid or Not Valid: _____

If Driver's License suspended, explain: _____

Driver's License restrictions (if any): _____

Employed by: _____

Work Address: _____

Work Phone Number: _____ Can you be called at work No Yes

Emergency Information

Is there any pertinent medical history or information that Oconee County Fire-Rescue should know about: No Yes

If yes, explain: _____

Blood Type: _____ List any allergies: _____

Do you carry medication(s): No Yes

If yes, name of medication(s) and where kept: _____

Personal Physician's Name: _____ Phone Number: _____

Hospital of choice: _____

Name of person to contact in case of emergency: _____

Phone Number: _____

Background Information

Do you have a High School Diploma or GED ? NOTE: You must provide a copy.

Have you been convicted of a D.U.I. in the last five (5) years? No Yes

If yes, give date(s) and disposition(s): _____

Since the age of seventeen (17) have you ever been charged or convicted of any criminal offense? No Yes

If yes, give date(s) and explanation: _____

Since the age of seventeen (17) have you ever been charged, indicted, or convicted of any type of drug related offense? No Yes

If yes, give offense, court, and probation officer's name: _____

Training Information

Do you have any previous experience serving with a fire department or rescue unit?

No Yes

Do you hold a valid certification card or completion certificate in any of the following?

(Check box)

- GFA Approved Firefighter I
Location of class: _____ Date Completed: _____

- Red Cross 10 Hr. First Aid or Equivalent
Expiration Date: _____

- CPR - American Heart Association/Red Cross
Expiration Date: _____

- CPR - American Heart Association/Red Cross Instructor
I.D.#: _____ Expiration Date: _____

- GEMA Rescue Specialist
Expiration Date: _____

- GEMA 16 Hr. Crash Victim Extrication
Location of class: _____

- GEMA 8 Hr. Awareness for Initial Response to Hazardous Materials Incident
Location of class: _____

- DOT/DHR Approved First Responder
Location of class: _____ Course Hours: _____

- GA DHR Emergency Medical Technician
I.D.#: _____ Expiration Date: _____

- GA Composite State Board of Medical Examiner Paramedic
License #: _____ Expiration date: _____

References

List Two (2) people not related to you and their address and phone number:

(1) _____

(2) _____

The information provided on this application is the truth to the best of my knowledge and belief. I understand that any falsification of information on this application will be grounds for rejection and or termination from Oconee County's Fire-Rescue.

I understand that this application will be used by Oconee County Fire-Rescue to assist in placement of personnel in the Fire Service and/or Rescue Unit and to provide Oconee County with information for insurance purposes.

I also agree to and understand that I must meet all training, meeting, and response requirements established by Oconee County Fire-Rescue and that I will be placed on a probationary period. I understand that I can be terminated during said probationary period without cause.

Upon completion, this application becomes property of Oconee County Fire-Rescue and will be retained in the confidential personnel files at the Oconee County Fire-Rescue Office.

TO PROCESS YOUR APPLICATION THE FOLLOWING MUST BE TURNED IN WITH
THE APPLICATION; FAILURE TO DO SO MAY RESULT IN THE APPLICATION
PROCESS BEING DELAYED AND YOU MAY MISS THE APPLICATION REVIEW DATE:
COMPLETED/LEGIBLE APPLICATION FORM
COPY OF A VALID GEORGIA DRIVER'S LICENSE
COPY OF HIGH SCHOOL DIPLOMA
SIGNED AND WITNESSED DRUG POLICY

APPLICANT'S SIGNATURE

DATE

Drug Test Consent and Information Release Form

I understand that one of the components of the Oconee County Drug and Alcohol Policy is a urine test for drugs and/or alcohol as a condition of employment. A positive test will result in:

- a) Denial of employment;
- b) Disciplinary Action to include termination of employment.

I authorize the testing laboratory to release the results of this drug and alcohol test only to the Oconee County Medical Review Officer or designee, the Oconee County Board of Commissioners and their legal counsel, the applicable Department Head, those Oconee County employees who have a valid need to know, or those involved in any appeal process should it become necessary. I understand that this information will otherwise be kept confidential and will not be released without my written consent or as is otherwise permitted by law. I release the medical personnel and any and all of their employee/owners or representatives from any and all liabilities arising from the release or use of the information derived from or contained in my drug results.

During the process of testing a urine specimen for drugs, the specimen is also tested for excessive dilution (excess water in the specimen). In order for the specimen to be a valid specimen, it must not be a dilute specimen. For 6 hours before the test, please do not drink more than 12 ounces of liquid including alcohol or caffeinated beverages (such as sodas, coffee, or tea) or take a diuretic (water pill) unless it is medically necessary. If you take diuretics prescribed by a physician, and it is medically necessary that you take the diuretic on the day of specimen collection, please inform the collector at the time that the specimen is collected. The prescription for the diuretic will need to be verified by the medical review officer if the specimen is dilute.

Read, acknowledged and consented to, this _____ day of _____,
20____.

Applicant's Name (Please Print)

Applicant's Signature

Witness Signature

Applicant's social security number

**Georgia Bureau of Investigation
Georgia Crime Information Center**

Georgia Driver's History Consent Form

I hereby authorize the Oconee County Fire Rescue
(fire department/law enforcement agency name)

to receive a copy of my Georgia driver's history information as part of my application for criminal justice employment, or for use relative to the performance of my official duties with this agency

Full Name (print)

Address

Sex

Date of Birth

Driver's License Number

Signature

Date

Name-Based Criminal History Record Information Consent/Inquiry Form

I hereby give consent for the Oconee County Fire Rescue to conduct an
Criminal Justice Agency
Inquiry and receive any Georgia criminal history record information pertaining to me which may be
contained in the files of any state or local criminal justice agency in Georgia.

Full Name (print):			
Address			
Sex	Race	Date of Birth	Social Security Number

This authorization is valid for 90/180/ _____ (circle one) days from date of signature.

I, _____ give consent to the above named to perform periodic
criminal history background checks for the duration of my employment with this company.

Signature _____
Date

Date of Inquiry: _____ Time of Inquiry: _____ Operator's Initials: _____
Purpose Code used: (check one)

<input type="checkbox"/>	Employment (E) – Provides <i>Georgia</i> Criminal History Record Information
<input type="checkbox"/>	Employment with Mentally Disabled (M) – Provides <i>Georgia</i> Criminal History Record Information
<input type="checkbox"/>	Employment with Elder Care (N) – Provides <i>Georgia</i> Criminal History Record Information
<input type="checkbox"/>	Employment with Children (W) – Provides <i>Georgia</i> Criminal History Record Information
<input type="checkbox"/>	Public Records (P) – Provides <i>Georgia Felony Convictions</i> Only

The inquiry resulted in the following: (check all that apply)

<input type="checkbox"/>	No Georgia CHRI results available.
<input type="checkbox"/>	Georgia CHRI attached/released.

<input type="checkbox"/>	No NCIC/GCIC Warrant results available.
<input type="checkbox"/>	Possible NCIC/GCIS Warrant. Contact Agency listed below.

Wanting Agency Name:	
Agency Telephone:	

Agency Designee Signature and Title _____
Date



Oconee County Fire Department

Bruce J. Thaxton, Fire Chief

Board of Commissioners

John Daniell, Chairman
Mark Thomas, Post 1
Chuck Horton, Post 2
W. E. "Bubber" Wilkes, Post 3
Mark Saxon, Post 4

I authorize any person(s), firm or organization to furnish Oconee County with any and all information concerning my previous or current employment, education, or any other information, personal or otherwise, with regard to any of the subjects covered by this application, and I release all such parties from all liability for any damage which may result from furnishing such information to Oconee County.

I authorize you to request, receive, and verify all information given in this application.

Printed Name

Signature

Date Signed

POST OFFER OF EMPLOYMENT MEDICAL INQUIRY

Responses to these questions are completely confidential and will be utilized only if necessary to determine if any reasonable accommodation is required for any work you may perform, whether any health condition may pose a direct threat of injury to yourself or others, to assist with treatment of any work-related injury, or for any other lawful purpose. This form does not request, nor should you provide, any information regarding family medical history, the medical condition of any family member, or any genetic information whatsoever.

Name: _____ Department: _____ Position: _____

To the best of your knowledge, do you have or have you had any of the following Medical conditions? (For "yes" responses, indicate the nature of injury or illness and name of physician in the remarks section.)

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--------------------------|--|--|--------------------------|--------------------------|----------|--------------------------|--------------------------|----------|--------------------------|--------------------------|-----------|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|--|---------------------------------|--|--|--------------------------|--------------------------|--------------|--------------------------|--------------------------|----------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|--|--------------------------|--------------------------|------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|--------|--------------------------|--------------------------|------------------------|--|----------|----------|--|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|-----------------------------|---|--|--|--------------------------|--------------------------|-------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|----------------|---|--|--|--------------------------|--------------------------|-------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|----------------|---|--|--|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|-----------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|-------------------|
| <table border="0"> <tr> <td style="width: 50px;">Y</td> <td style="width: 50px;">N</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Epilepsy</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Diabetes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Arthritis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Amputated foot, leg, arm or hand</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Loss of sight of one or both eyes or a partial loss of sight</td> </tr> <tr> <td colspan="3">Residual disability from</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Polymyelitis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cerebral palsy</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Multiple sclerosis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Parkinson's disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cardiovascular disorders</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Mental disability following confinement for treatment in a recognized medical or mental institution for a period in excess of six months</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hemophilia</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Sickle cell anemia</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Chronic osteomyelitis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Ankylosis on major weight-bearing joint</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Muscular dystrophy</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hearing loss</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hernia</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Carpal Tunnel Syndrome</td> </tr> </table> | Y | N | | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Amputated foot, leg, arm or hand | <input type="checkbox"/> | <input type="checkbox"/> | Loss of sight of one or both eyes or a partial loss of sight | Residual disability from | | | <input type="checkbox"/> | <input type="checkbox"/> | Polymyelitis | <input type="checkbox"/> | <input type="checkbox"/> | Cerebral palsy | <input type="checkbox"/> | <input type="checkbox"/> | Multiple sclerosis | <input type="checkbox"/> | <input type="checkbox"/> | Parkinson's disease | <input type="checkbox"/> | <input type="checkbox"/> | Cardiovascular disorders | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Mental disability following confinement for treatment in a recognized medical or mental institution for a period in excess of six months | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Sickle cell anemia | <input type="checkbox"/> | <input type="checkbox"/> | Chronic osteomyelitis | <input type="checkbox"/> | <input type="checkbox"/> | Ankylosis on major weight-bearing joint | <input type="checkbox"/> | <input type="checkbox"/> | Muscular dystrophy | <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss | <input type="checkbox"/> | <input type="checkbox"/> | Hernia | <input type="checkbox"/> | <input type="checkbox"/> | Carpal Tunnel Syndrome | <table border="0"> <tr> <td style="width: 50px;">Y</td> <td style="width: 50px;">N</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Compressed air sequelae</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Shoulder injury or problems</td> </tr> <tr> <td colspan="3">Back conditions (identify below)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>back injury</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>back pain which required medical treatment</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>back surgery</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>degenerative disc</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>multiple back strains</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>chronic back pain</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>herniated disc</td> </tr> <tr> <td colspan="3">Neck conditions (identify below)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>neck injury</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>neck pain which required medical treatment</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>neck surgery</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>degenerative disc disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>multiple neck strains</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>chronic neck pain</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>herniated disc</td> </tr> <tr> <td colspan="3">Knee conditions (identify below)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>left knee surgery</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>right knee surgery</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>other (explain)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hip replacement surgery</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Swelling of any joint which required medical treatment</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Surgery (explain)</td> </tr> </table> | Y | N | | <input type="checkbox"/> | <input type="checkbox"/> | Compressed air sequelae | <input type="checkbox"/> | <input type="checkbox"/> | Shoulder injury or problems | Back conditions (identify below) | | | <input type="checkbox"/> | <input type="checkbox"/> | back injury | <input type="checkbox"/> | <input type="checkbox"/> | back pain which required medical treatment | <input type="checkbox"/> | <input type="checkbox"/> | back surgery | <input type="checkbox"/> | <input type="checkbox"/> | degenerative disc | <input type="checkbox"/> | <input type="checkbox"/> | multiple back strains | <input type="checkbox"/> | <input type="checkbox"/> | chronic back pain | <input type="checkbox"/> | <input type="checkbox"/> | herniated disc | Neck conditions (identify below) | | | <input type="checkbox"/> | <input type="checkbox"/> | neck injury | <input type="checkbox"/> | <input type="checkbox"/> | neck pain which required medical treatment | <input type="checkbox"/> | <input type="checkbox"/> | neck surgery | <input type="checkbox"/> | <input type="checkbox"/> | degenerative disc disease | <input type="checkbox"/> | <input type="checkbox"/> | multiple neck strains | <input type="checkbox"/> | <input type="checkbox"/> | chronic neck pain | <input type="checkbox"/> | <input type="checkbox"/> | herniated disc | Knee conditions (identify below) | | | <input type="checkbox"/> | <input type="checkbox"/> | left knee surgery | <input type="checkbox"/> | <input type="checkbox"/> | right knee surgery | <input type="checkbox"/> | <input type="checkbox"/> | other (explain) | <input type="checkbox"/> | <input type="checkbox"/> | Hip replacement surgery | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of any joint which required medical treatment | <input type="checkbox"/> | <input type="checkbox"/> | Surgery (explain) |
| Y | N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Amputated foot, leg, arm or hand | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of sight of one or both eyes or a partial loss of sight | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Residual disability from | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Polymyelitis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral palsy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Multiple sclerosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Parkinson's disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiovascular disorders | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental disability following confinement for treatment in a recognized medical or mental institution for a period in excess of six months | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle cell anemia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic osteomyelitis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankylosis on major weight-bearing joint | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular dystrophy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hernia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Carpal Tunnel Syndrome | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Compressed air sequelae | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder injury or problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Back conditions (identify below) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | back injury | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | back pain which required medical treatment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | back surgery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | degenerative disc | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | multiple back strains | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | chronic back pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | herniated disc | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Neck conditions (identify below) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | neck injury | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | neck pain which required medical treatment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | neck surgery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | degenerative disc disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | multiple neck strains | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | chronic neck pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | herniated disc | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Knee conditions (identify below) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | left knee surgery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | right knee surgery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | other (explain) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip replacement surgery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling of any joint which required medical treatment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgery (explain) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
- Any other preexisting disease, condition, or impairment which is permanent in nature, or for which your doctor has indicated physical limitations or restrictions (Indicate details below in remarks)

Remarks: _____

I, _____ (Employee), attest that the above information is true and complete to the best of my knowledge.

Signature of Employee _____ Date _____

Signature of Employer _____ Date _____