For Local Personnel Files Only **Do Not Return To State Board**

Grant County Fire District # 3

1201 Central Ave S, Quincy WA 98848
509 787 2713

Report Of Physical Examination For Membership

Name _____ Birthdate: _____

Address _____How Long At This Address? _____

Occupation _____For Whom Employed? _____How Long? _____

MEDICAL EXAMINATION

History

Are you now in good health? _____ Do you have or previously had any disabilities whereby your full physical capacities are limited? Yes _____ No_____ If so, explain _____How you ever had any of the following diseases or conditions? Heart trouble _____, Kidney or urinary trouble? _____, Tuberculosis or other lung disease _____, Stomach ulcers or gastro intestinal disease _____, Diabetes _____, Epilepsy _____, Mental disease _____, Nervous system trouble _____, Rheumatism or Arthritis _____, Back trouble _____, Allergies such as asthma, hay fever, eczema _____, Vision defects _____, Hearing defects _____, Hernia _____, Piles _____, If so, explain_____

What serious illness, accidents, injuries, or operations have you had? _____

List any government, insurance compensations, or disability awards you have received. What for? _____

I hereby certify the above answers are full, complete, and true to the best of my knowledge:

_____

Applicant to sign in presence of examining M.D.

To Be Filled Out By Physician

Physical Examination

Name _____

Height _____ Weight_____ Pulse_____ Blood Pressure_____

General appearance _____

Vision uncorrected R _____ L _____ Corrected R _____ L _____

Head, Neck, Throat, Nose, Eyes, Ears: Findings _____

_____

Lung findings: _____

Heart: (a) Size _____ (b) Rhythm _____ (c) Murmurs _____

Abdomen: (a) Tenderness _____ (b) Masses _____

Inguinal Region: Right _____ Left _____

Spine: Motion _____ Curvature _____

Extremities: Limited motion or impaired function _____

Defects or deformities _____ Varicose Veins _____

Nervous System: Pupils _____ Knee jerks _____ Romberg _____

Tremors _____ Gait _____

Urinalysis: Albumin _____ Sugar _____ Physician Performing Exam _____ Date _____

Physician's Opinion: Capable of sustained arduous duty ___Capable of modified duty ___ Not qualified at this time ___

Limitations _____

Remarks or Recommendations:

Physician Signature_____ Date _____

TO BE FILLED OUT BY FIRE CHIEF

I do hereby certify that _____ became an active member of this department on the _____ day of _____ year _____ and at that time, to the best of my knowledge and belief, was in sound health and physically capable of performing the duties of a firefighter.

_____ Fire Chief