



Human Resources/Risk Management
 2 South Green Street, Sonora, CA 95370 * (209)533-5566 Fax: (209) 533-5901
Authorization for Medical Services

Date: _____

Name: _____ Job Title: _____

Treatment Authorized:

- DMV Physical ***Return Results to Employee – Do Not Fax***
- Drug Screen (Photo ID Required) Sent out DOT
- Breath Alcohol Testing (Photo ID Required) DOT
- Hepatitis B Vaccination

-or-

- Pre-employment physical

Circle which type of physical the employee needs to receive below:

<p><u>Safety</u> <u>Required:</u></p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Pre-employment Physical <input checked="" type="checkbox"/> Medical History <input checked="" type="checkbox"/> Drug Screen <input checked="" type="checkbox"/> Range of Motion <input checked="" type="checkbox"/> Vision exam <input checked="" type="checkbox"/> TB Skin Test <input checked="" type="checkbox"/> Urinalysis <input checked="" type="checkbox"/> Pulmonary Function <input checked="" type="checkbox"/> Audiometric 	<p><u>Non-Safety</u> <u>Required:</u></p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Pre-employment Physical <input checked="" type="checkbox"/> Medical History <input checked="" type="checkbox"/> Range of Motion <input checked="" type="checkbox"/> Vision Exam <input checked="" type="checkbox"/> Drug Screen 	<p><u>Optional for all Positions:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Spirometry <input type="checkbox"/> Audiometric <input type="checkbox"/> TB Skin Test <input type="checkbox"/> Stress Treadmill <input type="checkbox"/> HEP B & C Screen <input type="checkbox"/> Chest X-Ray <input type="checkbox"/> Lift Eval Clearance Form (Requires 2nd appointment at SRMC Physical Therapy Dept)
---	--	---

Authorizing Signature: _____
Department Head or Designee

Bill to: _____
Department Name and Client Number

Appointment Date / Time: _____

Treatment to be received at:

X	Job Care 19747 Greenley Rd #S2, Sonora, CA 95370 (209)536-3780
----------	--

Departments: It usually takes 3-5 days to get the physical results back. HR will notify you as soon as we receive the results. An employee may not begin work until you receive notification from HR.

PATIENT DEMOGRAPHICS

NAME: _____ DATE: _____

PHYSICAL ADDRESS: _____

MAILING ADDRESS (if different): _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

LIST ANY OTHER NAMES PREVIOUSLY USED (i.e. MAIDEN)

NAME OF EMPLOYER YOU ARE TESTING FOR:

Pre-Employment Medical History Profile

Name: _____ Date: _____

Birthdate: _____ Age: _____ Gender: _____ Social Security #: _____

Address: _____ Mailing: _____

Phone #: _____ Family Physician: _____

Person To Notify in Emergency: _____ Phone #: _____

Position You Have Applied For: _____

The purpose of this questionnaire is to gather the information concerning your health and physical condition, **both now and in the past**, to determine if you can safely perform the duties of the job for which you are now being considered. Please answer all the following questions as completely as you can. Explain any "YES" answers on the next page.

Never	Current	Past	Condition	Never	Current	Past	Condition
			Vision Problems				Musculoskeletal Problems (circle)
			Glasses/contacts				Broken bones/Dislocations
			Color Blindness				Neck (Pain Injury Surgery) Date: _____
			Loss of Vision Right Left				Back (Pain Injury Surgery) Date: _____
			Other				Shoulder RT LT (Pain Injury Surgery) Date: _____
			Hearing Problems				Elbow RT LT (Pain Injury Surgery) Date: _____
			Loss of Hearing Right Left				Wrist RT LT (Pain Injury Surgery) Date: _____
			Uses hearing aid				Knee RT LT (Pain Injury Surgery) Date: _____
			Exposure to loud noise				Ankle RT LT (Pain Injury Surgery) Date: _____
			Respiratory Problems				Swollen joints
			Frequent colds				Rheumatoid Arthritis/Osteoarthritis
			Asthma/Wheezing Meds: _____				Painful feet
			Tuberculosis Treated? _____				Other
			Chronic cough				Medical Problems
			Emphysema Meds: _____				Diabetes Medication
			Shortness of breath				Hepatitis Medication
			Other				Chronic abdominal pain
			Heart Problems				Cancer Treatment
			High blood pressure Meds: _____				Thyroid Disease Medication
			Heart murmur				Ulcers Medication
			Chest pain				Have you suffered any illness or injury which may affect your ability to perform the job duties outlined in the job description?
			Swelling of ankles				
			Leg pain with walking				
			Other				Any work condition that would require time away from work?
			Skin Problems (circle as appropriate)				Medication Allergies
			Sensitive to chemicals/latex				
			Shingles or recurrent herpes				
			Eczema/Psoriasis				
			Other				Childhood Illnesses
			Neurological Problems				Chickenpox Age
			Head injury Date: _____				Measles (Rubeola) Age
			Frequent headaches/migraines				German Measles Age
			Epilepsy/Seizures Meds: _____				Mumps Age
			Fainting spells				Immunizations
			Dizziness or Vertigo				TB skin test Date
			Trouble with nerves Meds: _____				BCG Vaccine Date
			Depression/Worry Meds: _____				Tetanus/Diphthria Date
			Other				MMR Date
							Smallpox Date
							Hepatitis B Date

Please complete next page and sign form

1. Which is your dominant hand? Right Left
2. How many days of work, in the last year, were missed due to illness or injury?
3. Are you currently being treated for a medical condition? _____
 If so, what condition? _____
4. List any work restrictions: _____
5. List past hospitalizations/surgeries (include date): _____

6. List current medications: _____

Please explain/describe, in as much detail, any questions on the prior page you answered "CURRENT" or "PAST".

I certify that the information provided on this health history, and all attachments are true and correct to the best of my knowledge, and I agree that falsification may be cause for dismissal. I agree to undergo a pre-employment exam, including such laboratory, x-ray exam and further medical clearance, as may be designated by the employer. I fully understand and agree that employment is and shall continue to be contingent upon meeting the employers' physical and health requirements. I also authorize companies, schools, employers, physicians or other persons named on my application for employment, and this medical record, to provide medical information requested by the employer and release these persons from all liability.

 Applicant's Signature

 Date

Clinician, please comment on any yes answers here

I certify under penalty of perjury that the above statements are accurate, to the best of my knowledge regarding the health history of the person named on this history profile.

 Clinician's Signature

 Date

AUTHORIZATION FOR RELEASE OF INFORMATION FROM MEDICAL RECORD

Patient _____
Last Name First Name Middle Initial Date of Birth

Address _____
Street, City and State Telephone Number

I, the undersigned, hereby authorize _____
Health Care or Health Services Provider

to provide from my medical record the information specified below to _____

for the purpose of evaluating health status in relation to particular job placement requirements.

Release or transfer of the information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity.

This authorization shall be valid until _____
Date

Signature _____
Social Security Number Date