Medical Statement of Personnel
(To be complete by the applicant)

NOTE: This form is designed to provide the individual in charge of all personnel a complete history of physical status as of the date indicated. If any of the questions are answered "YES," be sure the answer is fully explained.

Name: ____
Address: ____
City & State: __________________________ Zip: ________________

1. Birth Date: Month: __________ Day: _____________ Year: _______________________

2. Eyesight:
   a. Have you lost use of either eye? _____R ______ L ☐Yes ☐No
   b. Is peripheral (side) vision restricted? ☐Yes ☐No
   c. Are you color blind? ☐Yes ☐No
   d. Do you have, or have you ever had cataracts? ☐Yes ☐No
   e. Are actual deficiencies corrected by glasses or contacts? ☐Yes ☐No
   f. Date of last eye exam: ___________________________

3. Hearing:
   a. Do you have difficulty hearing normal conversation level? ☐Yes ☐No
   b. Do you use a hearing aid? ☐Yes ☐No

4. Diabetes:
   a. Have you ever been treated for diabetes? ☐Yes ☐No
   b. Describe current medication and dosage, if any, and method of administration under "Remarks"
   c. Date of latest blood sugar test: _____________________

5. Heart:
   a. Have you ever been treated for heart disease? ☐Yes ☐No
   b. Describe condition: ____
   c. Describe current medication and dosage, if any, under "Remarks"
   d. Do you have a pacemaker? ☐Yes ☐No
   e. Date of last treatment or check-up: _______________________________

6. Epilepsy:
   a. Have you ever been treated for epilepsy? ☐Yes ☐No
   b. If "Yes," when was you last seizure? _____________________________
   c. Describe current medication and dosage, if any, under "Remarks"

7. Blood Pressure:
   a. Have you ever been treated for high blood pressure? ☐Yes ☐No
   b. If "Yes," when were you treated? _________________________________
   c. What was your last reading? _____________________________________
   d. Describe current medication and dosage, f any, under "Remarks."

8. Limbs:
   a. Have you lost an arm or leg? ☐Yes ☐No
   b. Have you lost the use of an arm or leg? ☐Yes ☐No
   c. Does vehicle have special controls? ☐Yes ☐No
   d. If "Yes," to any of the above, describe under "Remarks"

9. Miscellaneous:

a. Have you ever had, or been treated for convulsions? ☐Yes ☐No

b. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "Remarks"

c. Have you ever had any fainting spells? ☐Yes ☐No

d. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "Remarks"

e. Have you ever been treated for loss of equilibrium? ☐Yes ☐No

f. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "Remarks"

g. Have you ever been treated for alcohol or drug abuse? ☐Yes ☐No

h. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "Remarks"

i. Have you ever been treated for mental illness? ☐Yes ☐No

j. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "Remarks"

10. Are you under the care of a physician for any condition not mentioned above that may affect your ability to participate in fire and emergency services? ☐Yes ☐No

Remarks:

The answers to the above are complete, accurate, and true to the best of my knowledge.

________________________________ __________________________

Signature of Person Named Above Date

Attending Physician Statement

____ has applied for membership with Victoria Fire and Rescue Company, Inc. Due to the strenuous nature of rescue work requires both physical and mental stability of personnel, this agency requests each applicant to complete a medical questionnaire and to obtain written verification from their physician certifying his/her ability to participate in the activities of the agency.

Physician Confirmation

Upon examination, I find no evidence of illness or injury which would preclude this individual from participating in any activities related to the fire or emergency medical services.

____ ____

Physician's Signature Date

____ ____

Physician's name (Please Print) Telephone Number

____

Address City State Zip