

Applicant Name \_\_\_\_\_ Last 4 Digits of SSN \_\_\_\_\_

**For OHR Use Only**

Department \_\_\_\_\_ Division: \_\_\_\_\_ Position \_\_\_\_\_

Clearance Date \_\_\_\_\_  Check here for temporary/seasonal positions.

OHR Specialist \_\_\_\_\_ Hiring Department Contact \_\_\_\_\_

**OFFICE OF HUMAN RESOURCES  
OCCUPATIONAL MEDICAL SERVICES  
255 Rockville Pike, Suite 125  
Rockville, Maryland 20850  
(240) 777-5118 Fax (240) 777-5132**

**MONTGOMERY COUNTY, MARYLAND  
REPORT OF APPLICANT'S MEDICAL HISTORY**

You have received an offer of employment conditioned on the result of this medical evaluation. The information submitted is used to determine your ability to perform the essential functions of the job for which you applied and could be used for evaluation in future workers' compensation claims. If necessary, you may request a reasonable accommodation consistent with provisions of the Americans with Disabilities Act and Montgomery County Personnel Regulations (MCPR), Section 8. See <http://www.montgomerycountymd.gov/HR/LaborRelations/PersonnelRegulation.html>. The aforementioned law and County regulation in part require that an applicant be able to perform the essential job functions, with or without a reasonable accommodation. The County will take appropriate action to comply with any such request. This form is to be completed and sent directly to Occupational Medical Services (OMS). Your employment application will not be further processed until OMS receives and evaluates this **completed** report. The information provided will be maintained in confidential medical files in accordance with MCPR, Section 4, and will be kept in the medical section of the Office of Human Resources (OHR). The information will be reviewed only by Occupational Medical Services or other authorized persons. Please print and use ink to complete this form. **The medical evaluation cannot proceed unless all items below are answered fully.**

**Note:** This form is both a County personnel record and a record of the County's retirement system. Any information presented on this medical history form may also be used to evaluate an individual's future eligibility for disability or disability retirement benefits. This form is not used to determine eligibility for insurance benefits, nor will this form be provided to health insurers without your written consent.

LAST NAME		FIRST NAME	MIDDLE NAME	POSITION APPLIED FOR	
HOME ADDRESS (STREET, CITY, STATE, ZIP CODE)		SOCIAL SECURITY NUMBER			
( )	( )	DATE OF BIRTH		AGE	SEX
HOME TELEPHONE		OFFICE TELEPHONE	EMERGENCY CONTACT (NAME, ADDRESS, PHONE)		
HEALTH CARE PROVIDER (NAME, ADDRESS, PHONE)					
DATE OF LAST PHYSICAL			DATE OF LAST CHEST X-RAY OR TB TEST		

Statement of Personal Health (in your own words):

Have you been medically evaluated by Montgomery County in the past as a job applicant?  Yes  No

If YES, state date and position:

\_\_\_\_\_  
\_\_\_\_\_

Do you currently have any physical or mental conditions or are you currently disabled in any way that may limit your ability to perform the job for which you have applied?  Yes  No

If YES, explain:

\_\_\_\_\_  
\_\_\_\_\_

Do you wear a hearing aid or use an assistive device such as (i.e. wheelchair, cane, crutches, walker, or artificial limb)?  Yes  No

If Yes, please specify:

\_\_\_\_\_  
\_\_\_\_\_

Do you have any disability requiring a reasonable accommodation in order for you to perform this job?  Yes  No

If YES, explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you been refused employment or been terminated from a job due to:

- 1. sensitivity to chemicals, dust, sunlight, etc.....  Yes  No
- 2. inability to perform certain motions.....  Yes  No
- 3. inability to assume certain positions.....  Yes  No
- 4. any other medical, psychological, or physical reason? .....  Yes  No

If YES to any above, give date(s) and explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you, within the past 3 years, had to change jobs because of a diagnosed injury or illness (physical or psychological)?  Yes  No

If YES, give date(s) and explain:

\_\_\_\_\_  
\_\_\_\_\_







Are you pregnant or is there a possibility you are?  Yes  No

Do you wear:  glasses \*contact lenses  artificial eye

\*If wearer of contact lenses, indicate whether:  Soft  Hard  Gas Permeable

Have you any medical or other restriction pertaining to driving a motor vehicle?  Yes  No

If YES, explain:

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Are you currently taking prescription medications?  Yes  No

If Yes, please list:

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Are you currently taking any over the counter medications (decongestants, antihistamines, cough medicines) or supplements (i.e. St. Johns Wort, Echinacea) that may cause drowsiness?  Yes  No

If Yes, please list:

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Are you currently on any special diets recommended by a health care provider?  Yes  No

If Yes, explain:

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Have you ever smoked or used tobacco of any type? .....  Yes  No

Do you currently smoke?.....  Yes  No

If Yes, to either question, how long and how much? \_\_\_\_\_

Do you drink alcoholic beverages?  Yes  No

If Yes, Check:  daily  weekly Daily or weekly amount:\_\_\_\_\_

Within the past 3 years, have you been advised by a health care provider to reduce your consumption of alcohol because of a health condition resulting from or made worse by drinking alcohol?  Yes  No  
If Yes, explain:

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To the best of your knowledge, have you had an exposure to any of the following either in your work or while engaged in a hobby?

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Mercury (scientific instruments, chlorine plants, dental offices).....                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Arsenic (insecticides) .....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Acrylamide (construction, grouting).....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Hexane (solvents, rubber cements, inks).....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Trichloroethylene (trichlor "tri", degreasing).....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Perchloroethylene (perchlor, perc, dry-cleaning industry).....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Pesticides.....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Methyl butyl keytone (MEK, inks) .....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Carbon Disulfide (rayon/rubber industry, labs) .....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Lead (jewelry, foundries, battery industries, ammunition) .....                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Toluene (solvents, lacquers, inks) .....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Methylene Chloride.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Carbon Monoxide (by-products of combustion) .....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Fumes or hazardous Gases.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Asbestos.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Industrial dust or flames.....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Radioactive material, lasers, x-rays, radar .....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 18. Frequent or prolonged exposure to extreme temperatures .....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 19. Loud industrial noise.....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 20. Firearms/guns.....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 21. Frequent or prolonged use of a chain saw.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 22. Frequent or prolonged use of lawn equipment or chippers.....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 23. Frequent or prolonged exposure to motorcycle noise.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 24. Frequent or prolonged use of industrial equipment that causes vibrations.....<br>(e.g. jackhammers). | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**If Yes,** describe by number the exposure and estimate dates and duration of exposure:

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Do you have any hobbies, such as the ones below, which could expose you to glues, solvents, or chemicals?

- 1. Painting.....  Yes  No
- 2. Furniture Refinishing.....  Yes  No
- 3. Lead Glass Making.....  Yes  No
- 4. Auto Body Work.....  Yes  No
- 5. Jewelry Making.....  Yes  No
- 6. Pottery Making or Ceramics.....  Yes  No
- 7. Other (please explain): \_\_\_\_\_  Yes  No

**If Yes**, estimate time involved in the activity:

\_\_\_\_\_  
\_\_\_\_\_

To the best of your knowledge, have you ever had an illness or symptoms resulting from exposure to a chemical or hazardous materials not listed above?  Yes  No

**If Yes**, give date(s) and explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In the past 3 years, have you regularly worn any of the following **protective equipment** in your previous work or while engaged in your hobby?

- 1. Ear plugs/muffs.....  Yes  No
- 2. Goggles/face mask.....  Yes  No
- 3. Dust mask.....  Yes  No
- 4. Respirator.....  Yes  No
- 5. Gloves.....  Yes  No
- 6. Apron or gown.....  Yes  No
- 7. \*Other .....  Yes  No

\*please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FIREFIGHTER/RESCUER POSITION ONLY ALCOHOL USE**

Are you, or have you been in the past 3 years, a volunteer firefighter or cadet with Montgomery County MD? **If Yes**, explain:  Yes  No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. Further, I understand the following:

1. That any offer of employment is conditioned on the results of this medical evaluation.
2. Any intentionally false or misleading statement may result in the rejection of my application for employment or in my discharge from County employment. Such a false or misleading statement may also exclude me from coverage in the County medical disability retirement or disability benefit programs.
3. That I may be required to provide additional medical information and/or undergo further medical evaluation as a condition of employment.
4. Upon your written request, a copy of this form or any component of your medical record will be made available to you in accordance with MCPR Section 4.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

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Physician/Nurse comments, summary, or elaboration of all pertinent data.

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Montgomery County Physician/Nurse Signature

\_\_\_\_\_ Date \_\_\_\_\_