Applicant Name _____ Last 4 Digits of SSN _____

☐ COVID19 Vaccine Requirement

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
27 Courthouse Square, Suite 184
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	
( )	( )			
HOME TELEPHONE	OFFICE TELEPHONE	DATE OF BIRTH	AGE	SEX

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:

_____

_____

Have you been a patient in a hospital or rehabilitation center within the past 3 years? ☐Yes ☐No

If YES, give date(s) and explain:

Have you, within the past 3 years, been advised to have surgery that you declined to have? ☐Yes ☐No

If YES, give date(s) and explain:

Applicant Name _____ **Last 4 Digits of SSN** _____

Within the past 3 years, have you had any of the following? (complete all 3 columns)

	Y	N		Y	N		Y	N
1. Abnormal Chest X-ray			24. Stroke			47. Shoulder/arm Condition		
2. Abnormal EKG			25. Intestinal Condition			48. Speech Impairment		
3. Allergies			26. Kidney/UTI condition			49. Post Traumatic Stress		
4. Blood in Urine			27. Liver Disease			50. Paralysis		
5. Bone Disease			28. Rheumatic Fever			51. Back or Neck Pain		
6. Chronic Sleep Disorder			29. Heart Palpitations			52. Rash or Skin Condition		
7. Chronic Cough			30. Pancreatitis			53. Loss of consciousness		
8. Chronic Diarrhea			31. Phlebitis/Blood Clot			54. Anemia		
9. Collapsed Lung			32. Pneumonia			55. Cancer or Tumor		
10. Detached retina			33. Poor Night Vision			56. Clinical Depression		
11. Diabetes			34. Prostate Cancer			57. Hernia		
12. Tuberculosis			35. Slipped/Ruptured Disc			58. Head Injury		
13. Stomach Ulcer			36. Loss of Limb/Finger/Toe			59. Alcoholism		
14. Varicose Veins			37. Significant Tremors/ Shaking			60. Epilepsy/Seizure		
15. Wheezing/Asthma			38. Sciatica or Neuritis			61. Learning Disability		
16. Yellow Jaundice			39. Arthritis or Gout			62. Drug Addiction		
17. Gall Bladder Condition			40. Dizziness/Fainting			63. Chronic Fatigue		
18. Heart Attack			41. Fractured Bone			64. Memory Impairment		
19. Heart Murmur			42. Severe Headaches			65. Swollen/Painful Joint		
20. Thyroid Condition			43. Psychological/Mental Condition			66. Bursitis		
21. High Blood Pressure			44. Hearing Impairment			67. Bleeding Disorder		
22. High Cholesterol			45. Cataracts			68. Other		
23. Hypoglycemia			46. Knee/leg/ankle/foot Condition					

Explain all YES answers by number. Be sure to include dates and types of treatments, where applicable.

Have you experienced the following within the past 3 years?

	Y	N		Y	N
1. Wheezing/Asthma			10. Leg Pain		
2. Hemorrhoids			11. Fear of Heights		
3. Chest Pain/Pressure			12. Diminished Night Vision		
4. Heart Palpitations			13. Frequent Dizziness/Fainting		
5. Double Vision			14. Significant Tremors/ Shaking		
6. Shortness of Breath			15. Fear of Close Spaces		
7. Frequent Indigestion			16. Frequent Infections		
8. Poor Urine Control			17. Significant Back or Neck Pain		
9. Significant Intestinal Discomfort			18. Recent Substantial Weight Change		
Explain all YES answers by number. Be sure to include dates and types of treatments, where applicable.					

Do you have allergies to any of the following? Check all that apply.

☐ Food	☐ Bee stings
☐ Soaps or detergents	☐ Pollen
☐ Metals, chromium	☐ Insect scales
☐ Nickel	☐ Animal dander
☐ Rubber	☐ House Dust
☐ Epoxy resins	☐ Industrial chemicals
☐ Plants (poison ivy)	☐ Others:

Check the box below if you have been immunized against:

☐ Hepatitis B	☐ Tetanus
☐ Rubella (German measles)	☐ Mumps
☐ Varicella (Chicken Pox)	☐ Rubeola (Measles)
☐ Polio	☐ Rabies
☐ Hepatitis A	☐ Other

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:

_____

_____

_____

Are you currently taking prescription medications? ☐Yes ☐No

If Yes, please list:

_____

_____

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:

_____

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

If Yes, explain:

_____

_____

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? **If Yes,** explain: ☐Yes ☐No

_____

_____

_____

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

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

_____

_____

_____

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): _____

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_____

Parents Signature (if minor child) _____ Date _____

****

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

_____

_____

_____

_____

_____

_____

_____

_____

Montgomery County Physician/Nurse Signature

_____Date_____

MONTGOMERY COUNTY FIRE AND RESCUE COMMISSION

APPLICANT DRUG/ALCOHOL TESTING NOTIFICATION

(Please print or type)

I, _____, understand that a urine screen for the presence of drugs/alcohol administered by Montgomery County Fire Rescue Occupational Medical Services, is a condition of my volunteer service. I further understand that the results of this urine screen will be released only to me and Montgomery County Fire Rescue Occupational Medical Services, and will be used solely to complete my application for volunteer service. The results of this screen will not be disclosed without my written consent to another person or agency for any other purpose, including any administrative, civil, or criminal proceeding.

I, _____, have been informed that Laboratory Corporation of America is the certified laboratory which will perform drug/alcohol testing on my urine specimen collected on _____in Fire Rescue Occupational Medical Services. I understand that I have the right to request independent testing of the same specimen at my own expense at another Federal and State certified laboratory if my urine specimen tests positive for drugs and/or alcohol.

_____

Print Name

_____ _____

Signature Date

Rev 3/03

Montgomery County Fire/Rescue Occupational Medical Services
27 Courthouse Square, Suite 180
Rockville, Maryland 20850
Phone: 240-777-5185

PARENTAL CONSENT FORM

To: Montgomery County Employee Medical Examiner

I am the parent/legal guardian of _____. I
(volunteer applicant)
hereby authorize the Montgomery County Occupational Medical Section to give the above named individual a medical examination which includes a chest x-ray, an exercise treadmill test, the drawing of blood and a tuberculin skin test. This medical examination is in connection with the participation by the above named individual with the Montgomery County Fire and Rescue Service. I hereby consent to the above named individual performing hazardous work as a firefighter / rescuer for Montgomery County Fire and Rescue Service. I further certify that the above individual is at least 16 years old and has completed or will be taking a course of study about firefighting, rescue, or basic emergency care.

_____ _____

Signature of Parent or Guardian *Date*

Approved 5/10/10
SAM

Montgomery County Government
Office of Human Resources
Fire/Rescue Occupational Medical Services

Consent Form for Collection - Pre-employment Drug/Alcohol Testing

I, _____, the parent/guardian of _____,
[Parent/guardian printed name] [Minor's printed name]

authorize Montgomery County Occupational Medical Services [OMS] to perform a medical examination on the above named individual. I certify that the above named individual is at least sixteen (16) years old.

I understand that the examination will include collection of a urine specimen to be tested for drugs and alcohol. The process for evaluating the specimen is as follows:

1. The individual completes the "Authorization To Obtain Specimen" and the "Authorization for Release of Information Relating to Drug/Alcohol Testing" forms and signs and dates them.
2. A specimen is collected from the individual, separated into containers to allow future retesting, and sent to the lab with the appropriate custody and control forms.
3. The results are received in OMS and reviewed by the Employee Medical Examiner [EME]
4. If the results are positive, the EME will call the individual who gave the specimen to conduct a telephone interview to determine if there is any medical indication for the positive result. If there is a medical indication for the results, the EME will certify the results as negative. If the EME determines there is no medical indication for the positive result, he will certify the drug screen results as confirmed positive and inform the individual of the right to a retest.
5. The EME will make three (3) reasonably spaced attempts within a 24-hour period to reach the individual to discuss the results before making his determination and certification.
6. If the EME is unable to reach him/her, or once the EME has spoken to the individual and confirmed the results as positive, a memorandum of notification of the positive results will be sent to the Manager in the Office of Human Resources (OHR) ten (10) days after the EME has determined the results to be positive. If the tenth day falls on a weekend or holiday, the memo is sent on the next business day. A copy of the memo sent to OHR and a copy of the individual's drug screen results are sent, via certified mail, to the individual and, if the individual is a minor, also to the parent or guardian identified below.

_____ I do not wish to be included in the telephone discussion of the results for my minor child.

_____ Please include me in the discussion of results with my minor child. I can be reached at the following number from 8 AM – 4:30 PM Monday through Friday.
(_____)_____-_____

I understand that the EME will discuss the results with my minor child if I am unable to be reached at the above number within 3 attempts.

_____ _____
Parent / Guardian Printed name Parent / Guardian Signature

Date: _____

Montgomery County Government

Non - DOT Authorization to Obtain Specimen for Drug Testing

Reason for Test [Check One]:

[ ] Pre-Employment **[ ] For cause**

[ ] Return to Duty **[ ] Follow-up**

I authorize Occupational Medical Services of the Montgomery County Government or any doctor, nurse, technician, laboratory personnel at any laboratory or medical center designated by Montgomery County Government to collect a ☐ breath sample for alcohol testing and a ☐ urine sample/specimen for drug testing. My sample/specimen was give on [enter date] _____ at Occupational Medical Services, 27 Courthouse Square, Suite 180, Rockville, MD, 20850.

I have been informed that the laboratory named below will perform the urine test for drugs and that this laboratory has been certified by the State of Maryland and the U.S. Department of Health and Human Services to perform employment-related drug testing.

Name of Laboratory: Labcorp

If the urine specimen is found to be positive for drugs, I understand that I am entitled to have the same specimen tested independently at a different laboratory which has been certified by the State of Maryland and the U.S. Department of Health and Human Services. If I elect to have the specimen tested independently, I must pay the costs of the test. A split specimen must be requested within 5-days of the MRO verifying a positive test. A list of certified laboratories is available at Occupational Medical Services.

I understand that the laboratory will report the drug test results to the Employee Medical Examiner of Montgomery County Government, Occupational Medical Services. A photocopy of this authorization will be as valid as the original, even though the photocopy does not contain an original writing of my signature.

Applicant/ Employee Printed Name: _____

Signature: _____

Address: _____

Witness: _____ Date: _____

Montgomery County Government

Non - DOT Authorization for Release of Information Related to Drug / Alcohol Testing

Reason for Test [Check One}:

[ ] Pre-Employment **[ ] For cause**
[ ] Return to Duty **[ ] Follow-up**

I, _____, authorize the release of the results of the drug / alcohol testing by the laboratory which conducted the test to the Employee Medical Examiner of Occupational Medical Services of the Montgomery County Government at 27 Courthouse Square, Suite 180, Rockville, MD 20850.

I further authorize Occupational Medical Services of release the results of the drug test as a finding of negative or confirmed positive to my Department Director or Designee.

If I am a current County employee who is applying for a transfer to, or appointment in, a position in a different County department or agency, or I am a County employee who is applying or a promotion within my current department (and submission to pre-employment drug testing is a prerequisite to appointment to the higher-level position), I understand that any confirmed positive drug or alcohol test result will also be reported to the director of the County department or agency in which I am currently employed.

If the test results are positive for the presence of alcohol, I also authorize release for the alcohol concentration to my Department Director or Designee.

This authorization is limited to information derived from the tests and evaluation performed on my urine sample/specimen obtained on [enter date] _____ at:

Occupational Medical Services
27 Courthouse Square, Suite 180
Rockville, MD 20850

This authorizes the release of this information solely to enable Montgomery County Government to make employee-related decisions.

A photocopy of this authorization will be considered as valid as the original, even though the photocopy does not contain an original writing of my signature.

Applicant/ Employee Printed Name: _____

Signature: _____

Witness: _____ Date: _____

Montgomery County Government
OCCUPATIONAL MEDICAL SERVICES
GRADED EXERCISE TEST (GXT) INFORMED CONSENT NOTICE

I, _____, understand that as part of my job-related physical examination, I am required by Montgomery County to undergo a Graded Exercise Test. Occupational Medical Services, and such assistants as may be designated, will administer the test. The staff members conducting the test are licensed healthcare professionals certified in Advanced Cardiac Life Support. All testing is supervised by a licensed clinician, who is present in Occupational Medical Services when testing is conducted.

This test is designated to measure my level of fitness. It is also a screening tool to evaluate any current, significant, heart disease and my risk for development of significant heart disease in the future.

I understand that I will walk on a motor driven treadmill. During the performance of physical activity, my electrocardiogram will be monitored and my blood pressure measured and recorded at periodic intervals. Exercise will be increased progressively until I reach the mets (a measurement of how much oxygen your body is consuming) for my position listed below without exceeding 90% of my predicted maximum heart rate based upon my age, I become distressed in any way, or I develop any abnormal response that the testing professional considers significant, whichever of the events occurs first.

Police Officer and Police Officer Candidates – 12.1 mets
Correction Officer and Correction Officer Applicants – 10.1 mets
Deputy Sheriff and Deputy Sheriff Applicants – 10.1 mets
Firefighter / Rescuer and Firefighter / Rescuer Applicants – 10.1 mets

I understand that I may terminate the test at any point (when I feel I am unable to proceed) by notifying the testing professional. My rating of "pass" or "fail" on the treadmill test itself is based upon my achieving the required mets without exceeding 90% of my predicted maximum heart rate based upon my age.

Every effort will be made to conduct the test in such a way as to minimize discomfort and risk. I understand, however, that there are potential risks (approximately 2-3 per 10,000 tests) associated with a Graded Exercise Test, just as there are risks associated with any routine medical procedure, including diagnostic tests. These include episodes of transient lightheadedness, fainting, chest discomfort and leg cramps. On very rare occasions, heart attack or sudden death may occur. I further understand that professional personnel furnished with appropriate equipment are available. These medical professionals are trained to administer initial emergency care until the Emergency Medical System (EMS) personnel arrive. This notice does not release the County's agents or employees of liability.

I have read and understand the above. I have been given an opportunity to ask questions about the Graded Exercise Test and my questions have all been answered to my satisfaction.

_____ _____

Employee / Applicant Signature Date

FRS N-95 Fit Testing

Test Date: _____

Member's Full Name: _____
Last Name *First Name* *M.I.*

Member FSID: _____

Affiliation:
☐ LFRD ☐ CAREER ☐ HHS ☐ Sheriff ☐ MCPD

Member Battalion:
☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
☐ PSHQ ☐ ECC ☐ FEI

Member Station: FS_____

LFRD:

☐ Career	☐ Silver Spring	☐ Takoma Park	☐ Hillandale
☐ Burtonsville	☐ Bethesda	☐ BCC	☐ Chevy Chase
☐ Cabin John	☐ Glen Echo	☐ Rockville	☐ Gaithersburg
☐ Kensington	☐ WVRS	☐ Laytonsville	☐ Damascus
☐ Upper Mont	☐ Hyattstown	☐ Germantown	☐ Sandy Spring

For Office Use Only

Test Location: OMS/FROMS

Mask Model: ☐ 3M-8210 ☐ Other N-95: _____

Taste Threshold:
☐ 10 ☐ 20 ☐ 30

Outcome:
☐ Pass ☐ Fail

Fit Tester: _____

Montgomery County
Office of Human Resources
Occupational Medical Services

Medical Determination of Readiness for Respirator Fit-Testing Form

Employee Name: _____ SS#: _____

Department: _____ Position: _____

To the Health Care Provider completing this form, check the appropriate items below:

_____ I certify that I have reviewed the "Medical History Form for Assessing Readiness For Respirator Mask Fitting Form"

After completing the review of the above form, I certify:

_____ The above named employee has been medically certified to wear a positive pressure self-contained breathing apparatus pending successful fit testing.

_____ The above named employee *is not cleared* for wearing a respirator at this time. Further medical evaluation is necessary to make a final determination.

_____ The above named employee may wear a negative pressure breathing apparatus with a tight full fit face piece pending successful fit testing.

_____ The above named employee is not recommended for *any* respirator use.

_____ The employee has been provided with a copy of this form.

The "Medical History Form for Assessing Readiness for Respirator Mask Fitting Form" has been:

_____ Filed in the employee's Occupational Medial Services medical record.

_____ Returned to the employee for his/her personal records.

_____ _____

Employee Medical Examiner/other Provider Printed Name Provider's Signature

_____

Date of Signature

Montgomery County Government
Fire/Rescue Occupational Medical Services
Medical History Form for Assessing Readiness
For Respirator Mask Fitting

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

Can you read (circle one): Yes/No

Note to employer: If the employee indicates he/she cannot read, he/she is to be referred to OMS for assistance in completing the questionnaire.

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Please read: Please complete this questionnaire during your work hours. Be sure to answer all questions as thoroughly as possible. When you have finished, place the form in an envelope marked 'Confidential', seal it, and send it to Occupational Medical Services [OMS]. If the Employee Medical Examiner determines an examination is necessary, you will be notified to schedule an appointment.

Part A Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:_____

2. Your name: _____ Social Security #: ___-__-____

3. Your age (to nearest year):_____ 4. Sex (circle one): Male/Female

5. Your height: ____ ft. ____ in. 6. Your weight: _____ lbs.

7. Your job title: _____ Dept: _____ Dept. Contact: _____

8. A phone number where you can be reached by OMS: _____

9. The best time to phone you at this number: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

11. Check the type of respirator you will use (you can check more than one category):

a. ____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
b. ____ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): Yes/No

If "yes," what type(s):_____

_____

Montgomery County Government
Fire/Rescue Occupational Medical Services
Medical History Form for Assessing Readiness
For Respirator Mask Fitting

Part A Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month: Yes/No

2. Have you **ever had** any of the following conditions?

a. Seizures (fits)	Yes	No
b. Diabetes (sugar disease)	Yes	No
c. Allergic reactions that interfere with your breathing	Yes	No
d. Claustrophobia (fear of closed-in places)	Yes	No
e. Trouble smelling odors	Yes	No

3. Have you **ever had** any of the following pulmonary or lung problems?

a. Asbestosis	Yes	No
b. Asthma	Yes	No
c. Chronic bronchitis	Yes	No
d. Emphysema	Yes	No
e. Pneumonia	Yes	No
f. Tuberculosis	Yes	No
g. Silicosis	Yes	No
h. Pneumothorax (collapsed lung)	Yes	No
i. Lung cancer	Yes	No
j. Broken ribs	Yes	No
k. Any chest injuries or surgeries	Yes	No
l. Any other lung problem that you've been told about	Yes	No

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

a. Shortness of breath	Yes	No
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	Yes	No
c. Shortness of breath when walking with other people at an ordinary pace on level ground	Yes	No
d. Have to stop for breath when walking at your own pace on level ground	Yes	No
e. Shortness of breath when washing or dressing yourself	Yes	No
f. Shortness of breath that interferes with your job	Yes	No
g. Coughing that produces phlegm (thick sputum)	Yes	No
h. Coughing that wakes you early in the morning	Yes	No
i. Coughing that occurs mostly when you are lying down	Yes	No
j. Coughing up blood in the last month	Yes	No
k. Wheezing	Yes	No
l. Wheezing that interferes with your job	Yes	No
m. Chest pain when you breathe deeply	Yes	No

n. Any other symptoms that you think may be related to lung problems — Yes No

5. Have you **ever had** any of the following cardiovascular or heart problems?

a. Heart attack — Yes No
b. Stroke — Yes No
c. Angina — Yes No
d. Heart failure — Yes No
e. Swelling in your legs or feet (not caused by walking) — Yes No
f. Heart arrhythmia (heart beating irregularly) — Yes No
g. High blood pressure — Yes No
h. Any other heart problem that you've been told about — Yes No

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest — Yes No
b. Pain or tightness in your chest during physical activity — Yes No
c. Pain or tightness in your chest that interferes with your job — Yes No
d. In the past two years, have you noticed your heart skipping or missing a beat — Yes No
e. Heartburn or indigestion that is not related to eating — Yes No
f. Any other symptoms that you think may be related to heart or circulation problems — Yes No

7. Do you **currently** take medication for any of the following problems?

a. Breathing or lung problems — Yes No
b. Heart trouble — Yes No
c. Blood pressure — Yes No
d. Seizures (fits) — Yes No

8. If you've used a respirator, have you **ever had** any of the following problems? (If you've never used a respirator, check the following space and go to question 9:) ___

a. Eye irritation — Yes No
b. Skin allergies or rashes — Yes No
c. Anxiety — Yes No
d. General weakness or fatigue — Yes No
e. Any other problem that interferes with your use of a respirator — Yes No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? — Yes No

Montgomery County Government
Fire/Rescue Occupational Medical Services
Medical History Form for Assessing Readiness
For Respirator Mask Fitting

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you **ever lost** vision in either eye (temporarily or permanently) Yes No

11. Do you **currently** have any of the following vision problems?

a. Wear contact lenses Yes No
b. Wear glasses Yes No
c. Color blind Yes No
e. Any other eye or vision problem Yes No

12. Have you **ever had** an injury to your ears, including a broken ear drum? Yes No

13. Do you **currently** have any of the following hearing problems?

a. Difficulty hearing Yes No
b. Wear a hearing aid Yes No
c. Any other hearing or ear problem Yes No

14. Have you **ever had** a back injury? Yes No

15. Do you **currently** have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet Yes No
b. Back pain Yes No
c. Difficulty fully moving your arms and legs Yes No
d. Pain or stiffness when you lean forward or backward at the waist Yes No
e. Difficulty fully moving your head up or down Yes No
f. Difficulty fully moving your head side to side Yes No
g. Difficulty bending at your knees Yes No
h. Difficulty squatting to the ground Yes No
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs Yes No
j. Any other muscle or skeletal problem that interferes with using a respirator Yes No

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen? Yes No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you're working under these conditions? Yes No

Montgomery County Government
Fire/Rescue Occupational Medical Services
Medical History Form for Assessing Readiness
For Respirator Mask Fitting

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (**e.g.**, gases, fumes, or dust), or have you come into skin contact with hazardous chemicals? Yes No

If "yes," name the chemicals if you know them:_____

_____

_____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below?

a. Asbestos	Yes	No
b. Silica (**e.g.**, in sandblasting)	Yes	No
c. Tungsten/cobalt (**e.g.**, grinding or welding this material)	Yes	No
d. Beryllium	Yes	No
e. Aluminum	Yes	No
f. Coal (for example, mining)	Yes	No
g. Iron	Yes	No
h. Tin	Yes	No
i. Dusty environments	Yes	No
j. Any other hazardous exposures	Yes	No

If "yes," describe these exposures:_____

_____

_____

4. List any second jobs or side businesses you have:_____

_____

5. List your previous occupations:_____

_____

6. List your current and previous hobbies:_____

_____

7. Have you been in the military services? Yes No

If "yes," were you exposed to biological or chemical agents (either in training or combat)? Yes No

8. Have you ever worked on a HAZMAT team? Yes No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)? Yes No

If "yes," name the medications if you know them:_____

Montgomery County Government
Fire/Rescue Occupational Medical Services
Medical History Form for Assessing Readiness
For Respirator Mask Fitting

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters	Yes	No
b. Canisters (for example, gas masks)	Yes	No
c. Cartridges	Yes	No

11. How often are you expected to use the respirator(s)? (Circle "yes" or "no" for all answers that apply to you)

a. Escape only (no rescue)	Yes	No
b. Emergency rescue only	Yes	No
c. Less than 5 hours **per week**	Yes	No
d. Less than 2 hours **per day**	Yes	No
e. 2 to 4 hours per day	Yes	No
f. Over 4 hours per day	Yes	No

12. During the period you are using the respirator(s), is your work effort:

a. **Light** (less than 200 kcal per hour) Yes No

If "yes," how long does this period last during the average shift? ____hrs.___mins.

Examples of a light work effort are **sitting** while writing, typing, drafting, or performing light assembly work; or **standing** while operating a drill press (1-3 lbs.) or controlling machines.

b. **Moderate** (200 to 350 kcal per hour) Yes No

If "yes," how long does this period last during the average shift ____hrs. ___mins.

Examples of moderate work effort are **sitting** while nailing or filing; **driving** a truck or bus in urban traffic; **standing** while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; **walking** on a level surface about 2 mph or down a 5-degree grade about 3 mph; or **pushing** a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

c. **Heavy** (above 350 kcal per hour) Yes No

If "yes," how long does this period last during the average shift ____hrs. ___mins.

Examples of heavy work are **lifting** a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; **shoveling; standing** while bricklaying or chipping castings; **walking** up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

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Medical History Form for Assessing Readiness
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13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? Yes No

    If "yes," describe this protective clothing and/or equipment:_____

    _____

14. Will you be working under hot conditions (temperature exceeding 77 deg. F)? Yes No

15. Will you be working under humid conditions? Yes No

16. Describe the work you'll be doing while you're using your respirator(s):

    _____

    _____

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

    _____

    _____

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

    Name of the first toxic substance:_____
    Estimated maximum exposure level per shift:_____
    Duration of exposure per shift_____
    Name of the second toxic substance:_____
    Estimated maximum exposure level per shift:_____
    Duration of exposure per shift:_____
    Name of the third toxic substance:_____
    Estimated maximum exposure level per shift:_____
    Duration of exposure per shift:_____
    The name of any other toxic substances that you'll be exposed to while using your respirator:

    _____

    _____

    _____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue or security):

I certify that I have read and understood the questions and reviewed my responses. My answers are complete and accurate to the best of my knowledge and belief.

Signature _____ Date _____

MONTGOMERY COUNTY GOVERNMENT
OCCUPATIONAL MEDICAL SECTION
PULMONARY FUNCTION QUESTIONNAIRE AND TEST

NAME: _____ EMPLOYEE ID NUMBER _____
JOB TITLE. WORK SITE _____

Do you smoke currently cigarettes, cigars or a pipe? ___yes ___no
If yes: How many years? _____ How much? _____ per day.
Have you ever been a smoker in the past? ___yes ___no
If yes: How many years? _____ When did you stop? _____
In the past year; Did you work in a dusty job? ___yes ___no
If yes, was exposure: Mild ____ Moderate ____ Severe ____
Were you exposed to gas or chemical fumes in your work? ___yes ___no
If yes, was exposure: Mild ____ Moderate ____ Severe ____
In the past year: Were you exposed to toxic fumes in your job? ___yes ___no
If yes, was exposure: Mild ____Moderate ____ Severe ____.
Nature of fumes if known: _____
Do you use a SCBA or other type of respirator on the job? ___yes ___no
How often? ___ ___ What Kind? _____
Are you currently taking medications? ___yes ___no
If yes, Name of medication _____ purpose _____
Are you suffering from a cold or allergies today? ___yes ___no
Have you ever had exposure to asbestos on the job? ___yes ___no
Explain: _____

In the past year have you had:

Asthma	yes___ no___
Bronchitis	yes___ no___
Chest Surgery	yes___ no___
Pneumonia	yes___ no___
Hayfever	yes___ no___
Tuberculosis	yes___ no___
Epilepsy	yes___ no___
Rheumatic Fever	yes___ no___
Diabetes	yes___ no___
Cancer	yes___ no___
Kidney Disease	yes___ no___
Bladder Disease	yes___ no___
Jaundice	yes___ no___
Chest Pain	yes___ no___
Other	yes___ no___

FOR OFFICE USE ONLY

Glue Top Section Only

Please comment on any yes answers:

_____

Do you have:?

__ frequent colds	yes___ no___
__ chronic cough	yes___ no___
shortness of breath climbing steps one flight or walking?	yes___ no___

Employee's Signature: _____ Date: _____
Technician Comments: _____

Physician Signature: _____

Interpretation: _____