CITY OF OCEAN CITY

SEASONAL PHYSICAL

The objective of this evaluation is only to determine if the individual is capable of performing the essential function of the position offered.

TO BE COMPLETED BY APPLICANT:

NAME _____ POSITION _____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Telephone ( ) _____-_____

ADDRESS _____

Medical History – Have you ever had or have you now any of the following?
(For each "Yes" checked, please register remarks on reverse side.)

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
		a. Frequent severe headaches			h. High or low blood pressure			o. Excessive drinking habit			v. Record of traffic convictions
		b. Dizziness or fainting spells			i. Stomach trouble			p. Attempted suicide			w. Record of other conditions
		c. Unconscious for any reason			j. Kidney stone or blood in urine			q. Motion sickness requiring drugs			x. Neck injury
		d. Eye trouble except glasses			k. Sugar or albumin in urine			r. Military medical discharge			y. Work/mva injury
		e. Hay fever			l. Epilepsy or fits			s. Medical rejection from or for military service			z. Back injury
		f. Asthma			m. Nervous trouble of any sort			t. Rejection for life insurance			aa. Skull injury
		g. Heart trouble			n. Any drug or narcotic habit			u. Admission to hospital			bb. Other illnesses

MEDICAL TREATMENT WITHIN PAST 5 YEARS

DATE	NAME AND ADDRESS OF PHYSICIAN CONSULTED	REASON

LIST NAME AND ADDRESS OF YOUR PRESENT FAMILY DOCTOR WHO LAST GAVE YOU A PHYSICAL EXAMINATION

APPLICANT'S DECLARATION

I hereby certify that al statements and answers provided by me in this examination form are complete and true to the best of my knowledge. I further certify that all prior medical problems have been listed and explained to the City or the examining physician. I understand that giving in complete or false information is grounds for dismissal and forfeiture of related benefits. I also understand that any offer of employment is subject to satisfactorily completing a physical examination.

Signature of Applicant (In Ink) _____ **Date** _____

TO BE COMPLETED BY EXAMINING PHYSICIAN:

Notes:

Check each item in appropriate column (Enter NE if not evaluated.)	Normal	Abnormal	Check each item in appropriate column (Enter NE if not evaluated.)	Normal	Abnormal
Skin			Heart		
Eyes			Lungs		
Ears			Abdomen		
Nose			Neurological		
Throat			Orthopedic Defects		
Teeth			Extremities		

Physical examination
Height _____ Weight _____ BP _____ Pulse _____ Hernia _____

Date of examination	Medically	Physician's Signature
	□ Passed □ Not Passed	

EMPLOYEE – TAKE THIS FORM TO PHYSICIAN
(PHYSICIAN RETAINS COMPLETED FORM)

SEASONAL PHYSICAL VERIFICATION FORM

CITY OF OCEAN CITY

This Form MUST be returned to your Supervisor before reporting to work.

_____

NAME OF PATIENT (Employee) - Please Print

_____ _____

DEPARTMENT POSITION

THIS SECTION TO BE COMPLETED BY PHYSICIAN

PLEASE CHECK ONE:

( ) ABLE TO PERFORM JOB DUTIES

( ) UNABLE TO PERFORM JOB DUTIES

( ) ABLE TO PERFORM JOB DUTIES WITH ACCOMMODATION(S)

List of restrictions:

_____

_____

_____

_____ _____

NAME OF TREATING PHYSICIAN PHYSICIAN STAMP

_____

SIGNATURE OF PHYSICIAN DATE

2011