Part A: MEDICAL HISTORY STATEMENT

To be completed by the Applicant

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

INSTRUCTIONS:
Complete prior to the physical examination and present to the examining physician at the time of examination. All questions must be answered completely and accurately. The original or a copy must be retained in a personnel file by the appointing agency.

Name: ____ **D.O.B.:** ____/____/________
Last First Middle Month Day Year

Address: ____
City State Zip Code

Telephone#: ______________________ **SS# (Last 4 digits only)** __________
Including area code

CURRENT MEDICATIONS: (Include prescription and/or over the counter and specify reason for taking)

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ALLERGIES: List all known allergies (list drug or environmental allergies and reaction)

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PAST MEDICAL HISTORY: List ALL hospitalizations and operations since childhood:
(Include type of surgery, date of surgery, any complications or other significant information)

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Have you EVER had any of the following types of medical conditions: [check all that apply and provide an explanation below]

[ ] **1. CANCER:** any type of cancer

[ ] **2. MAJOR INFECTIOUS DISEASE**: such as tuberculosis, hepatitis, HIV/AIDS, rheumatic fever, etc.

[ ] **3. NEUROLOGICAL PROBLEMS**: such as seizure disorder, stroke, concussion, severe headache, skull fracture, recurrent vertigo, balance problems, encephalitis, meningitis, tremors, multiple sclerosis, Huntington's chorea, peripheral neuropathy, etc.

[ ] **4. PSYCHOLOGICAL PROBLEMS**: such as depression, manic episodes, psychotic episodes, post traumatic stress disorder, etc.

[ ] **5. EYE PROBLEMS**: such as eye injury, color blindness, poor night vision (night blindness), glaucoma, blindness in one or both eyes, very poor vision when not corrected, etc.

[ ] **6. EAR PROBLEMS**: such as injury, chronic or long lasting infections, use of a hearing aid

[ ] **7. NOSE PROBLEMS**: such as nose injury, allergies, nasal bleeding, loss of sense of smell, chronic or long lasting infections, etc.

[ ] **8. MOUTH OR THROAT PROBLEMS**: such as injury, major dental work, any kind of speech defect, chronic or long lasting infections, abnormality of nose, mouth or throat that would interfere with wearing a respirator, etc.

[ ] **9. LUNG PROBLEMS**: such as asthma, emphysema, chronic or recurrent bronchitis, pneumonia, tuberculosis or lung abscess, etc.

[ ] **10. HEART AND CIRCULATION PROBLEMS**: such as a heart murmur, heart disease, heart attack, irregular rhythm, valve abnormalities, varicose veins, phlebitis, peripheral vascular disease, Raynaud's disease and blood pressure conditions, etc.

[ ] **11. DIGESTIVE SYSTEM PROBLEMS**: such as any kind of ulcer disease, hepatitis or liver disorder, any kind of colitis, Crohn's disease, ulcerative colitis, irritable bowel syndrome, esophageal disorders, pancreatitis, gallstones, stomach or intestinal bleeding, etc.

[ ] **12. HORMONE OR ENDOCRINE PROBLEMS**: such as diabetes, thyroid disease, parathyroid or adrenal problems, etc.

[ ] **13. URINARY TRACT PROBLEMS**: such as kidney stones, pyelonephritis (kidney infection), nephrosis, single functioning kidney, polycystic kidney disease, repeated bladder infections, etc.

[ ] **14. HERNIA**: such as inguinal, umbilical, ventral, femoral, hiatal or incisional hernias.

[ ] **15. MUSCLE, BONE AND JOINT PROBLEMS**: such as chronic back or neck pain, fibromyalgia, back or neck disk disease, osteomyelitis (bone infection), muscular dystrophy, arthritis, spinal curvature, loss of a finger or toe, knee injuries, joint replacements, ACL repairs, shoulder injuries and carpal tunnel.

[ ] **16. BLOOD SYSTEM PROBLEMS**: such as anemia, hemophilia or bleeding disorder, white blood cell abnormality, etc.

EXPLANATION OF ANY YES ANSWERS: (Identify by number and use additional paper if necessary; write name, last 4 SS#, sign and date. **Include any restrictions or limitations that exist.**

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MALES ONLY

[ ] ˙**17.** Prostate problems such as enlargement or prostatitis?

[ ] ˙**18.** Genital problems such as epididymitis or testicular injury?

FEMALES ONLY

[ ] ˙**19.** Curre ntly pregnant?

[ ] ˙**20.** History of endometriosis, pelvic inflammatory disease, abnormal Pap smear, PMS or other problem with your menstrual cycle?

IMMUNIZATIONS

[ ] **21.** Have you ever had a positive TB test?

21a. If Yes, provide date___________________

[ ] **22.** Have you received Hepatitis B vaccinations?

[ ] **23.** Date of last tetanus (lockjaw) immunization? ___________________________
(If date unknown, or over 10 years ago, tetanus must be updated)

OCCUPATIONAL HISTORY

Have you ever been exposed to any of the following, whether at home, work, military or any other setting?
(Check any that apply and provide an explanation below)

[ ] **2(.** Repetitive Loud Noises (Including guns, jet engines, loud machinery)?

[ ] **2) .** Chemical exposure to skin or lungs?

[ ] **2* .** Dusty conditions (sandblasting, grinding, mining or drilling of rock, coal, silica, asbestos)?

[ ] **2+.** Have you ever received or applied for a pension or compensation because of a disability or injury?

If yes, what percentage? _____ % Provide documentation, including any restrictions

[ ] ˙˙˙˙˙˙˙˙**&, .** Have you ever missed any work because of back or neck discomfort?

ÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁ**&, a.** If yes, how many days of work last year did you miss? _____

ÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁ**&, b.** If yes, how many days a year do you have back or neck pain? _____

[ ] ˙˙˙˙˙˙˙˙**&- .** Have you ever had a motor vehicle accident causing back or neck pain?

[˙**3$.** Are you limited or unable to perform any physical activity because of muscle or joint discomfort?

[˙**3%** Do you have any missing limbs, digits or non-functioning joints?

[˙**3&.** Have you ever been advised by a physician to avoid lifting above a certain weight limit?

[˙**3' .** Have you ever been advised by a physician to avoid sitting or standing over a certain time?

[˙**3(.** Have you ever worked in law enforcement?

ÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁ**3(a.** If yes, have you ever missed more than three consecutive days of work for any medical or ÁÁÁpsychological problem?

[ ] **3) .** Have you ever served in any of the armed forces?

ÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁ**3) A.** If yes, have you ever missed more than three consecutive days of service for any medical or ÁÁÁpsychological problem?

[˙**3* .** Do you have any difficulty in properly holding, aiming or firing a handgun, rifle or shotgun?

[˙**3+.** Do you have any difficulty driving at high speeds in a motorized vehicle?

[ ] ˙˙˙˙˙˙˙˙**' , .** Have you ever had an automobile accident while driving over sixty (60) miles per hour?

[ ] ˙˙˙˙˙˙˙˙**' - .** Have you ever had any automobile accidents as a result of losing control of your vehicle?

[ ] ˙**4$.** Do you have any difficulty driving for three (3) consecutive hours without stopping?

[ ] ˙**4%** Do you have any difficulty running for five (5) consecutive minutes without stopping?

[ ] ˙**4&.** Have you ever passed out, temporarily lost control of any part of your body, or had blackout spells (episodes you do not remember)?

EXPLANATION OF ANY YES ANSWERS: (Identify by number and use additional paper if necessary)
May use additional sheets of paper; write name, last 4 SS#, sign and date.
Include any restrictions or limitations that exist.

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PENALTY:
Any falsification, withholding or failure to answer all questions completely and accurately may disqualify you from receiving or retaining employment or certification as a Nebraska Law Enforcement Officer.

CERTIFICATION:
I hereby certify that there are no willful misrepresentations, omissions or falsifications in the foregoing statements and answers to questions, and that all statements and answers are true and correct to the best of my knowledge and belief.

______________________________	______________________
Signature of Applicant (ink)	Date Signed

PHYSICIAN REVIEW:

______________________________	______________________
Signature of Physician (ink)	Date Reviewed

____
Printed Name and Address of Physician Completing Review

Part B: MEDICAL EXAMINATION REPORT
To be completed by Physician

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

INSTRUCTIONS:
To be completed by either a physician or surgeon licensed to practice medicine in the State of Nebraska or by a physician or surgeon authorized to practice medicine in accordance with the rules and regulations of the U.S. Armed Forces following an actual physical examination. The original or a copy of this report must be retained in a personnel file by the appointing agency. **All items must be completed unless specifically noted.**

Name: ________________________________ **Date of Birth:** __________´ _____
Last First Middle Month Day Year

Gender: ____________________ **Height:** ___________________ **Weight:** ______________________

PLEASE PROVIDE AN EXPLANATION FOR ANY ABNORMAL RESULTS

SECTION 1 – VISION

Visual Acuity: **If applicant wears glasses or contacts, test and record acuity with and without glasses**

Without glasses: R-20 / ______ L-20 / ______ Both-20 / ______
With glasses: R-20 / ______ L-20 / ______ Both-20 / ______

Depth Perception: [ ] Normal [ ] Abnormal ________________________________

Color Perception: [ ] Normal [ ] Abnormal ________________________________

Peripheral Vision: [ ] Normal [ ] Abnormal ________________________________

SECTION 2 – HEARING

Hearing Acuity tested by an (check one): [ ] Audiogram - or - [ ] 15’ whispered conversation

Right Ear: [ ] Normal [ ] Abnormal ________________________________
Left Ear: [ ] Normal [ ] Abnormal ________________________________

SECTION 3 – PERIPHERAL VASCULAR SYSTEMS and CARDIOVASCULAR

Blood Pressure: __________________________ Resting Pulse: ________________________________

Cardiac Examination: [ ] Normal [ ] Abnormal ________________________________

Peripheral Circulation: [ ] Normal [ ] Abnormal ________________________________

EKG (if necessary) [ ] Normal [ ] Abnormal [ ] Not required ____________________

HEART: [ ] Normal [ ] Abnormal ________________________________

SECTION 4 – RESPIRATORY

LUNGS: [ ] Normal [ ] Abnormal ______________________________

SECTION 5 – GASTROINTESTINAL SYSTEM

ABDOMEN: [ ] Normal [ ] Abnormal ______________________________

SECTION 6 – MUSCULOSKELETAL SYSTEM

MUSCULOSKELETAL: [ ] Normal [ ] Abnormal ______________________________

SECTION 7 – GENITORINARY SYSTEM

GENITORINARY: [ ] Normal [ ] Abnormal ______________________________

SECTION 8 – NEUROLOGICAL SYSTEM

NEUROLOGICAL: [ ] Normal [ ] Abnormal ______________________________

SECTION 9 – DERMATOLOGICAL SYSTEM

SKIN: [ ] Normal [ ] Abnormal ______________________________

SECTION 10 – ENDOCRINE AND METABOLIC SYSTEM

URINALYSIS: [ ] Normal [ ] Abnormal ______________________________

SECTION 11 – CONTAGIOUS INFECTIOUS DISEASE

TB Skin Test: [ ] Normal [ ] Abnormal ______________________________

EXPLANATION OF ANY ABNORMAL RESPONSES (Identify by SECTION).
May use additional sheets of paper; write name, last 4 SS#, sign and date.

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Are there any conditions, physical, emotional, or mental, which, in your opinion, suggest further examination? If yes, provide an explanation.

[ ] Yes [ ] No

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Do you have any reservations about this candidate's ability to physically or emotionally perform required duties? If yes, provide an explanation.

[ ] Yes [ ] No

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Physician's Signature (Must be M.D. or D.O.) Date

Name and Address of Physician
(Print or Stamp)