

**Volunteer Fire Department**

\_\_\_\_\_  
Department and Address

\_\_\_\_\_  
Phone

**Report Of Physical Examination For Membership**

Name \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Address \_\_\_\_\_ How Long At This Address? \_\_\_\_\_  
Occupation \_\_\_\_\_ For Whom Employed? \_\_\_\_\_ How Long? \_\_\_\_\_

**MEDICAL EXAMINATION**

**History**

Are you now in good health? \_\_\_\_\_ Do you have or previously had any disabilities whereby your full physical capacities are limited? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, explain \_\_\_\_\_ Have you ever had any of the following diseases or conditions? Heart trouble \_\_\_\_\_, Kidney or urinary trouble? \_\_\_\_\_, Tuberculosis or other lung disease \_\_\_\_\_, Stomach ulcers or gastro intestinal disease \_\_\_\_\_, Diabetes \_\_\_\_\_, Epilepsy \_\_\_\_\_, Mental disease \_\_\_\_\_, Nervous system trouble \_\_\_\_\_, Rheumatism or Arthritis \_\_\_\_\_, Back trouble \_\_\_\_\_, Allergies such as asthma, hay fever, eczema \_\_\_\_\_, Vision defects \_\_\_\_\_, Hearing defects \_\_\_\_\_, Hernia \_\_\_\_\_, Piles \_\_\_\_\_, If so, explain \_\_\_\_\_  
What serious illness, accidents, injuries, or operations have you had? \_\_\_\_\_  
List any government, insurance compensations, or disability awards you have received. What for? \_\_\_\_\_

*I hereby certify the above answers are full, complete, and true to the best of my knowledge:*

\_\_\_\_\_  
Applicant to sign in presence of examining M.D.

**To Be Filled Out By Physician**

**Physical Examination**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

General appearance \_\_\_\_\_

Vision uncorrected R \_\_\_\_\_ L \_\_\_\_\_ Corrected R \_\_\_\_\_ L \_\_\_\_\_

Head, Neck, Throat, Nose, Eyes, Ears: Findings \_\_\_\_\_

Lung findings: \_\_\_\_\_

Heart: (a) Size \_\_\_\_\_ (b) Rhythm \_\_\_\_\_ © {Year} {Company name}.

Abdomen: (a) Tenderness \_\_\_\_\_ (b) Masses \_\_\_\_\_

Inguinal Region: Right \_\_\_\_\_ Left \_\_\_\_\_

Spine: Motion \_\_\_\_\_ Curvature \_\_\_\_\_

Extremities: Limited motion or impaired function \_\_\_\_\_

Defects or deformities \_\_\_\_\_ Varicose Veins \_\_\_\_\_

Nervous System: Pupils \_\_\_\_\_ Knee jerks \_\_\_\_\_ Romberg \_\_\_\_\_

Tremors \_\_\_\_\_ Gait \_\_\_\_\_

Urinalysis: Albumin \_\_\_\_\_ Sugar \_\_\_\_\_ Physician Performing Exam \_\_\_\_\_ Date \_\_\_\_\_

**Physician's Opinion:** Capable of sustained arduous duty \_\_\_ Capable of modified duty \_\_\_ Not qualified at this time \_\_\_

Limitations \_\_\_\_\_

Remarks or Recommendations:

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_

**TO BE FILLED OUT BY FIRE CHIEF**

I do hereby certify that \_\_\_\_\_ became an active member of this department on the \_\_\_\_\_ day of \_\_\_\_\_ year \_\_\_\_\_ and at that time, to the best of my knowledge and belief, was in sound health and physically capable of performing the duties of a firefighter.

\_\_\_\_\_ Fire Chief