HERKIMER COUNTY EMPLOYMENT PHYSICAL EXAMINATION

Herkimer County contracts with Slocum-Dickson Medical Group to provide employment physical examinations on all prospective employees at a rate of $75.00 per exam; telephone 895-7916, Ilion clinic. If the service of another physician is used, Herkimer County will reimburse up to $75.00 for the examination.

ATTENTION SERVICE PROVIDERS: Claims should be submitted within 90 days from the date of service to insure full payment.

Patient’s Full Name  Place of Employment/Name of Department

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VISION: Far: Right 20/ Corrected to 20/  Far: Left 20/ Corrected to 20/

CLINICAL EVALUATION

Check EACH item in proper column; Enter NE if not evaluated

1. Head, Neck, Face, Scalp
2. Nose and Sinuses
3. Mouth and Throat
4. Teeth and Gingiva
5. Ears (perf. of drum, etc.)
6. Eyes (lids, conjunctiva, etc.)
7. Pupils and Ocular Motion
8. Lungs, Chest and Breasts
9. Heart (include estimate of cardiac function)
10. Vascular System (Varicosities, etc.)
11. Abdomen and Viscera (include hernia)
12. Ano-rectal (pilonidal)
13. Endocrine System
14. G-U System
15. Upper Extremities (strength, range of motion)
16. Feet
17. Lower Extremities (as for upper)
18. Spine, other musculo-skeletal
19. Skin and Lymphatics
20. Neurologic
21. Psychiatric (specify any personality deviations noted)

Lab Data (if indicated)*


*Laboratory tests as required by the hiring department or at the discretion of the examining physician, upon PRIOR APPROVAL of the Herkimer County Personnel Department (867-1115).

The Certification below MUST be completed by the examining physician AND County of Herkimer voucher MUST be submitted before payment for services can be rendered.

I HEREBY CERTIFY that this is a true record of the examination for the above candidate and that I have found him/her _____qualified _____not qualified physically for the duties of ________________________________.

Title of Position  Date

Examining Physician’s Signature  Telephone Number  Address
HERKIMER COUNTY EMPLOYMENT HEALTH REPORT

To Be Completed by the Applicant.
Please print in ink or type all information.

ATTENTION YOUTH:  If you have had a physical for school within the past year, please have the physician/nurse complete the reverse side of this Health Report.

Name _____________________________________ Social Security Number ____________________________

Address ____________________________________________________________

Primary Physician (Name) ____________________________________________
Address ____________________________________________________________

FAMILY HISTORY: (list familial diseases: Diabetes, Tuberculosis, Mental Illness, Other)
________________________________________________________________________
________________________________________________________________________

PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name _____________________________________ Relationship ____________________________
Address ____________________________________________________________
Telephone No. ________________________________

PERSONAL HISTORY:  Date of Birth: _____________________

Circle those of the following diseases or conditions the applicant has had:

- Chicken pox
- Measles - English or Red
- Mumps
- Scarlet Fever
- Whooping Cough
- Diphtheria
- Rheumatic Fever – residual damage
- Frequent Colds
- Frequent Sore Throats
- Otitis Media – residual impairment of hearing
- Sinusitis
- Tonsillitis
- Bronchitis
- Pneumonia
- Congenital or other Heart problems
- Hay Fever
- Rheumatoid Arthritis
- Epilepsy
- Nervous Breakdown
- Emotional Breakdown
- Tuberculosis or TB contact
- Diabetes
- Anemia
- Malaria
- Infectious Jaundice or Hepatitis
- Poliomyelitis – residual effects
- Kidney disease
- Orthopedic problems
- Chronic intestinal problems
- Malignancy
- Asthma
- Eczema

Applicant Signature ___________________________ Date ___________________________