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.

<table>
<thead>
<tr>
<th>Patient’s Full Name</th>
<th>Place of Employment/Name of Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Age</td>
</tr>
<tr>
<td>Blood Pressure:</td>
<td>Pulse:</td>
</tr>
<tr>
<td>Color Vision/test used:</td>
<td>Hearing:</td>
</tr>
<tr>
<td>VISION:</td>
<td>Far:</td>
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<tr>
<td></td>
<td>Far:</td>
</tr>
</tbody>
</table>

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 _________________________________.

Examining Physician’s Signature ___________________________ Date ______________________
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:**

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

Date of Birth: __________________

Chorea
Hay Fever

Chicken pox
Chorea
Hay Fever

Measles - English or Red
Rheumatoid Arthritis
Hay Fever

- Rubella (German)
Epilepsy

Mumps
Nervous Breakdown

Scarlet Fever
Emotional Breakdown

Whooping Cough
Speech Defect

Diphtheria
Tuberculosis or TB contact

Rheumatic Fever – residual damage
Diabetes

Frequent Colds
Anemia

Frequent Sore Throats
Malaria

Otitis Media – residual impairment
Infectious Jaundice or Hepatitis

of hearing
Polymyelitis – residual effects

Sinusitis
Kidney disease

Tonsillitis
Orthopedic problems

Bronchitis
Chronic intestinal problems

Pneumonia
Malignancy

Congenital or other Heart problems
Asthma

Applicant Signature ___________________________ Date ___________________________