

HEALTH QUESTIONNAIRE

(With Physician's Report)

STD. 610 (REV. 6/2009) (Page 1 of 4)

STATE LAW AND THE AMERICANS
WITH DISABILITIES ACT REQUIRE APPLICANTS
TO FILL IN QUESTIONS ON PAGES 1 AND 2 OF THIS FORM
ONLY AFTER A JOB OFFER HAS BEEN MADE

DATE JOB OFFER MADE

SOCIAL SECURITY NUMBER (Optional - See Privacy Statement below.)

THIS AREA TO BE COMPLETED BY HIRING AGENCY — COMPLETED QUESTIONNAIRE WILL BE RETURNED TO HIRING AGENCY

| | | | | |
|--|---------|--------------------------|--------------------|--|
| APPLICANT NAME (Last) | (First) | (Middle) | HIRING AGENCY NAME | |
| APPLICANT ADDRESS (Number and Street) | (City) | (State) | (ZIP Code) | AGENCY ADDRESS |
| CLASS TITLE AND POSITION NUMBER OF VACANCY | | | | HIRING MANAGER'S NAME AND TELEPHONE NUMBER |
| APPOINTMENT TYPE | | DESIRED APPOINTMENT DATE | | CERTIFICATION NUMBER |
| <input type="checkbox"/> PERMANENT <input type="checkbox"/> TAU <input type="checkbox"/> LIMITED TERM (If reinstatement, enter dates of previous State employment.) | | CURRENT OCCUPATION | | |
| <input type="checkbox"/> REINSTATEMENT | | | | |

THIS AREA TO BE COMPLETED BY THE APPLICANT

DO NOT LEAVE YOUR PRESENT EMPLOYMENT TO ACCEPT A POSITION IN STATE SERVICE UNTIL YOU HAVE BEEN SPECIFICALLY NOTIFIED TO REPORT FOR WORK. MEDICAL CLEARANCE IS REQUIRED PRIOR TO EMPLOYMENT IN STATE SERVICE.

Your answers to the following questions will be evaluated in conjunction with the essential functions of the desired position. In addition, a physical examination may be required. "YES" answers to questions 1 - 43 below must be explained in the space provided on the back of this form.

| | | | | | | |
|---|-------------------------------|---------------------------------|--------|---|-----|----|
| BIRTH DATE | <input type="checkbox"/> MALE | <input type="checkbox"/> FEMALE | HEIGHT | WEIGHT | | |
| For questions 1–31, have you ever had or do you have the following: | | | | | | |
| ITEM | | YES | NO | ITEM | YES | NO |
| 1. Lung or respiratory trouble, including bronchitis, tuberculosis, or asthma | | | | 27. Gall bladder trouble | | |
| 2. Residuals of poliomyelitis | | | | 28. Kidney or bladder trouble | | |
| 3. Hepatitis, jaundice, or other liver ailments | | | | 29. Shortness of breath | | |
| 4. Cancer, malignant tumor, or cysts | | | | 30. Any speech impairment | | |
| 5. Diabetes or sugar in urine | | | | 31. History of addiction to drugs or alcohol | | |
| 6. Pernicious anemia, leukemia, or other blood disorder or ailment | | | | 32. Do you wear or have you ever worn glasses? | | |
| 7. Mental illness | | | | 33. Do you or have you ever worn contact lenses? | | |
| 8. Any disorder of the nervous system | | | | 34. Have you had any eye injury, surgery, or disease? | | |
| 9. Seizure disorder or loss of consciousness | | | | 35. Are you blind in one eye? | | |
| 10. Severe headaches or migraine | | | | 36. Are you blind in both eyes? | | |
| 11. Heart trouble—including circulatory disease | | | | 37. Do you wear a hearing aid or have you had at any time a problem with your hearing? | | |
| 12. Rheumatic fever | | | | 38. Do you have any existing temporary medical condition such as broken bones, recovery from surgery, pregnancy, etc.? If yes, list condition and anticipated date of recovery on Page 2. | | |
| 13. Any defect of bones or joints, including amputations, dislocations, or broken bones | | | | 39. Are you at present under a doctor's care for any condition? Give reason and doctor's full name and address. | | |
| 14. Rheumatism, arthritis, or bursitis | | | | 40. Are you taking any medication now or in the last 12 months? If yes, what? | | |
| 15. Back pain or back injury | | | | 41. Have you ever been hospitalized? If yes, list reason and date of hospitalization. | | |
| 16. Head injury | | | | 42. a. Have you had an illness or injury which caused you to lose time from work? | | |
| 17. Any problems with hips, knees, ankles, or feet | | | | b. Does this illness or injury continue to limit your ability to perform certain types of work? | | |
| 18. Any problems with hands, elbows, or shoulders | | | | 43. Have you ever had any other illness, injury or physical condition not named above (exclude minor problems such as colds, flu, etc.)? | | |
| 19. Fainting spells or dizziness | | | | | | |
| 20. Skin rash from work | | | | | | |
| 21. Allergies | | | | | | |
| 22. Sensitivity to dust or smoke | | | | | | |
| 23. High or low blood pressure | | | | | | |
| 24. Varicose veins | | | | | | |
| 25. Stomach or duodenal ulcer or other bowel problem | | | | | | |
| 26. Rupture or hernia | | | | | | |

CONFIDENTIAL

PRIVACY NOTICE

(Continue on reverse.)

Official Responsible: Medical Officer, State Personnel Board, 801 Capitol Mall, Sacramento, CA 95814-4806; **Authority:** Government Code Section 18931; **Purpose:** The information you furnish will be used to evaluate your medical fitness to carry out the duties of the position applied for without endangering the health and safety of yourself or others; **Providing Information:** Medical clearance is required prior to employment in State service; **Effects of Not Providing Information:** Omission or misrepresentation may result in placement in a position where the duties or work environment could be hazardous. A misrepresentation or omission may be cause for adverse employment action; **Access:** Your medical records will be maintained in a confidential manner and may be reviewed by contacting the employing agency's personnel office.

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(To be completed by a licensed physician and surgeon only after a job offer has been made)

TO THE PHYSICIAN: The attached Health Questionnaire must be completed and submitted to you by the person whose name appears below. It is intended to assist you in conduct of the examination. You are requested to complete the medical examination report. **The Hiring Agency is responsible for payment of the fee.** See page 4 for instructions.

APPLICANT'S SOCIAL SECURITY NUMBER (Optional)

ALL ITEMS BELOW ARE MANDATORY--COMPLETED REPORT SHOULD BE RETURNED TO HIRING AGENCY

| | | | |
|--|---------|----------|--|
| APPLICANT'S NAME (Last) | (First) | (Middle) | HIRING AGENCY NAME |
| APPLICANT'S ADDRESS (Number and Street) | (City) | (State) | (ZIP Code) |
| CLASS TITLE AND POSITION NUMBER OF VACANCY | | | HIRING MANAGER'S NAME AND TELEPHONE NUMBER |

| | | |
|---|--------------------------|----------------------|
| APPOINTMENT TYPE <input type="checkbox"/> PERMANENT <input type="checkbox"/> TAU <input type="checkbox"/> LIMITED TERM <input type="checkbox"/> PEACE OFFICER (If reinstatement, enter dates of previous State employment.) <input type="checkbox"/> REINSTATEMENT _____ | DESIRED APPOINTMENT DATE | CERTIFICATION NUMBER |
| CURRENT OCCUPATION | | |

DOCTOR: Write comments on any positive or negative findings for evaluation of applicant. (If more space is needed, use reverse of this form and/or a separate sheet of paper.) Examine color vision only when required in Minimum Qualifications.

| | | | | | | | | | | | |
|---|---|---|---|-------|--|----------------------|-----|------|------|------|------|
| 1. HEIGHT | 2. VISION <input type="checkbox"/> GLASSES <input type="checkbox"/> CONTACT LENSES | 2A. COLOR VISION TESTING REQUIRED <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL <input type="checkbox"/> ISHIHARA | | | | | | | | | |
| WEIGHT(Without heavy clothing or shoes) | UNCORRECTED | | 3. HEARING (Ordinary conversation at 15 feet considered normal) | | | | | | | | |
| | NEAR | DISTANT | | RIGHT | LEFT | AUDIOMETRY (If done) | | | | | |
| | Right 20/ | | | / 15 | / 15 | Right | 500 | 1000 | 2000 | 3000 | 4000 |
| | Left 20/ | | | | | Left | | | | | |
| | Both 20/ | | | | HEARING AID USED <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | |

| | | |
|---|--------------------------|----------------------|
| 4. HEAD (Eyes, ears, nose, mouth, throat) | 5.(A) RESTING PULSE RATE | 5.(B) BLOOD PRESSURE |
|---|--------------------------|----------------------|

| | |
|---------------------------------|---|
| 6. LUNGS (Breath sounds, rales) | 7. HEART (enlargement, rhythm, sounds) AND CIRCULATORY SYSTEM |
|---------------------------------|---|

8. NERVOUS SYSTEM (Reflexes, motor strength, atrophy, sensory changes, or any abnormal reflexes)

| | |
|---|--------|
| 9. ABDOMEN (G.I. system, liver, spleen, masses, scars, herniae, etc.) | HERNIA |
|---|--------|

| | |
|--|--|
| 10. GENITOURINARY SYSTEM INCLUDING KIDNEYS | 11. RECTAL Fissure Fistul Hemorrhoids |
|--|--|

| | |
|--|--|
| 12. SPINE (Deformity, tenderness, range of motion) | 13. EXTREMITIES (Strength, range of motion, deformities, atrophy or sensory changes) |
|--|--|

| | |
|---|-------------------------------|
| 14. SKIN AND LYMPHATICS, SIGNIFICANT SCARRING | 15. VARICOSE VEINS (Severity) |
|---|-------------------------------|

| | |
|--|-----------------------------------|
| 16. URINALYSIS Specific Gravity Albumin Sugar | 17. ANY WORK LIMITATION (Specify) |
|--|-----------------------------------|

| | |
|---|--|
| 18. PSYCHIATRIC EVALUATION (Any mental disorder observed) | |
|---|--|

| | | |
|--------------------------------------|--|-----------------------------|
| 19. PHYSICIAN'S SIGNATURE (Required) | PHYSICIAN'S NAME AND ADDRESS - (Required - Please print) | TELEPHONE NUMBER (Required) |
|--------------------------------------|--|-----------------------------|

| | | |
|-------------|--|---|
| DATE SIGNED | | PHYSICIAN'S TAXPAYER I. D. NUMBER (FEIN or SSA number - Required) |
|-------------|--|---|

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NOTICE TO PHYSICIANS AND CLINICS

The State of California requires preplacement physical examinations for certain classes of employment. The State also has many employees who are required to have a physical examination at the time of renewal of their Class I or II driver's license, when the possession of the license is required for the position.

If the hiring agency is not identified, do not perform the examination. The State Personnel Board does not have the authority to pay for examinations.

REPORTS

The medical report should be sent to the Hiring Agency shown on Page 1, unless you are requested by the person examined to mail this medical report directly to the State Personnel Board Medical Office, 801 Capitol Mall, Sacramento, California 95814-4806.

BILLINGS

Please send your bill for this examination **to the Hiring Agency as indicated on Page 1.** Include your Federal Employer Identification Number or Social Security Number for tax reporting purposes.

The State Hiring Agency will pay the fee for this Medical Examination Report up to a maximum determined by the Department of Health Services and set forth in the State Administrative Manual (Section 0190.1). The current fee allowance may be obtained from the Hiring Agency shown on Page 1. If there should be additional studies or examinations required for more complete evaluation of the individual, these examinations will be at the expense of the applicant.