## WESTERLY FIRE DEPARTMENT PHYSICAL FORM 7 UNION ST. WESTERLY R.I. 02891

Date	<b>:</b>		
Nam	e:		
Date	of Birth:		
Yes	No Check one per question		
[]	[] Any issue with eye sight? Provide last eye doctor visit		
[]	[] Do you wear glasses/contact lens?		
[]	[] Do you have trouble hearing normal conversations?		
[]	[] Do you use hearing aids?		
[]	[] Have you ever been treated for Diabetes?		
[]	[] Are you on medication? List each medication, its dosage and reason for taking medication.		
[]	[] Have you ever been treated for Heart Disease, high blood pressure, cholesterol or		
	similar condition? Described condition.		
[]	[] Do you have pacemaker?		
[]	[] Have you ever been treated for Epilepsy?		
[]	[] Have you ever been treated for Asthma or COPD?		
[]	[] Have you ever been treated for high blood pressure?		

[]	[] Is your high blood pressure o	controlled with medication?		
[]	<ul><li>[] Have you ever been treated for Alcohol or Drug Abuse?</li><li>[] Have you ever been treated for mental illness?</li></ul>			
[]				
[]	<ul> <li>[] Are there any restrictions on your vehicle operator's license?</li> <li>[] Are you capable of climbing multiple flights of stairs while wearing approx. 70 lbs of equipment?</li> <li>[] Are you capable of moving heavy loads or equipment?</li> </ul>			
[]				
[]				
[]	[] Do you have any issues with balance, stoop, kneel, crawl, and reaching overhead for prolonged periods of time?			
Whe	n was your last physical?			
	answers to the above are comp wledge.	lete, accurate, and true to the best of my		
heal that	th conditions that may affect my	ency will be utilized solely to alert the agency of any ability to perform my duties. I further acknowledge form will be held confidential and will not be shared agement.		
Member's signature		Date		
	owing a complete physical, the ighting duties:	above individual is authorized to participate in		
With	n no restrictions []			
With	n restrictions [] please list res	trictions		
Phys	sician/PA/APRN signature	Date		