Franklin County Self-Insurance Plan
355 West Main Street, Suite 428
Malone, NY 12953

Post-Offer Pre-Employment Physical
Per Workers' Compensation Self-Insurance Plan Local Law

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In accordance with Local Law No. 2 Franklin County's Self-Insurance Plan for Worker's Compensation, a post-offer pre-employment physical examination of designation positions within the County and Participants in the Plan is required. An offer of employment in these specific positions is contingent upon successful completion of this requirement. The physical examination is based on the essential job functions of the position being filled; thus, a copy of the job description must be included in this process.

All physical examination information and documentation is kept strictly confidential and retained in a separate, confidential medical file.

INTRUCTIONS TO HIRING ENTITY: Complete Part 1A and 1B. Enter your address in Box 1 in order to receive the form/bill from the physician directly. If you instruct the potential employee to return the completed physical form to you following the exam, please advise the doctor of your intentions. Once received from physician, review and sign on Page 5. Submit the completed physical form and the physician's bill to Franklin County Self-Insurance Plan, 355 W. Main Street, Suite 428, Malone, NY 12953. The hiring authority will be reimbursed the approved allowance amount as per Local Law No. 2.

INSTRUCTIONS TO EMPLOYEE: Complete and sign Part 2, Candidate Section. Bring the entire form to the physician listed in Part 1A. If you are unable to attend the appointment at the date and time assigned, contact the Hiring Entity. Leave the form with the physician who will return it completed to the Hiring Entity **unless directed otherwise**.

INSTRUCTIONS TO PHYSICIAN: Review Part 2 (candidate's responses) and provided job description. Complete Part 3 as outlined in Part 1B, sign and return to the Hiring Entity listed in Part 1A unless the employee was instructed to return the completed form directly. Send your bill to the Hiring Entity.

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PART 1A: TO BE COMPLETED BY HIRING ENTITY

#1	**Hiring Entity/ Address for Doctor to return form:**	

#2	**Candidate's Name:**	
	Appointment Date & Time:	
	Doctor's Office Address:	

PART 1B: TO BE COMPLETED BY HIRING ENTITY

DOCUMENTATION FOR THE PHYSICIAN/PRACTITIONER PERFORMING PHYSICAL EXAMINATION

The examining physician/practitioner shall conduct a medical history and administer a medical examination, which must include, but is not limited to, the following **checked** components.

Check		**Findings**	
		Normal / Negative	**Abnormal / Positive**
(x)	Basic Physical		
( )	Hearing Test **required along with basic physical**		
( )	Vision Test **required along with basic physical**		
( )	Urinalysis **required along with basic physical**		
( )	Drug Screening (10 panel) **required along with basic physical**		
	Other:		

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PART 2: CANDIDATE SECTION (COMPLETE BEFORE VISITING PHYSICIAN.)

Name (Print):	**DOB:**	**Male ( ) or Female ( )**
Address: _____	**Social Sec. #:**	**Phone #:**
Family Physician:	**Department hiring you:**	
Address of Physician:	**Position being offered:**	

Answer Questions Below:	**YES**	**NO**
➢ Have you ever applied for or received a Pension, Workers' Compensation or Disability Benefits?		
➢ Check appropriate box items listed below and circle medical topic if applicable.		
➢ Impairment of hearing or of sight of either eye.		
➢ Dizziness, fainting, convulsions or stroke.		
➢ Heart disease, high blood pressure, heart attack, irregular pulse, varicose veins, or blood clots.		
➢ Lung Disease, tuberculosis, asthma, emphysema, persistent cough.		
➢ Appendicitis, ulcers, stomach trouble, liver disease, gall bladder disease, hernia, intestinal disease or rectal disease.		
➢ Arthritis, rheumatism, sciatica, gout, or any disorder of the muscles or bones of the back, spine or joints.		
➢ Amputation, fracture, or loss of use of an arm, leg, hand, foot, fingers, or toes.		
➢ Rheumatic fever, syphilis, diabetes, epilepsy, cancer or AIDS.		
➢ Emotional, mental, or nervous disorder.		
➢ Complication with pregnancy or delivery.		
➢ Headaches either frequent or severe.		
➢ Have you ever had or been advised to have an operation?		
➢ Have you ever had or been advised to have an EKG?		
➢ Have you ever had or been advised to have an X-ray?		
➢ Do you have any allergies? If yes, indicate what you are allergic to below.		
➢ Do you use tobacco products? If yes, type and how often: _____		
➢ Do you drink alcohol? If yes, number of alcoholic beverages in an average week: _____		
➢ Do you use "entertainment" or "recreational" drugs?		
➢ **In your opinion, are you now in good health and fully able to do the work for which you are applying?**		

If yes to any question above, please describe: _____

_____

_____

Do you take any medications regularly? Yes ___ No ___ If yes, give names of medicines and their dosages.

_____

_____

CANDIDATE'S CONSENT AND CERTIFICATION:

1. I have carefully read and completed the foregoing information in the health questionnaire and that my answers are true to the best of my knowledge and belief. Any untrue statement made herein or any concealment of facts in this physical examination form shall be just cause for dismissal from service regardless of when such facts may be discovered.
2. I agree to such physical examination by a company-designated physician as may be required; employment is contingent on the satisfactory passing and approval thereof.
3. I understand that employment is contingent upon successful completion of this physical examination.
4. I understand and agree to authorize the review of this and other pertinent information for purposes related to determining my fitness for employment. Consistent with the Privacy Act Statement, I authorize the release to my employing agency of all information contained on this form and all other forms generated as a direct result of my pre-employment assessment and physical examination.

Candidate Signature: _____ Date: _____

PART 3: PHYSICIAN SECTION:

(REVIEW PART 1B, PART 2 & JOB DESCRIPTION; COMPLETE PART 3)

Examination									
Height:		Weight:		Pulse:		Blood Pressure			
Vision: Uncorrected:	Left		Vision: Corrected:			Regular Hearing:	Left	Normal ( )	Decreased ( )
	Right						Right	Normal ( )	Decreased ( )
Color Vision:						Hearing Aide:	( ) with ( ) without		

	Normal	Abnormal	NE			Normal	Abnormal	NE
HEENT					MS			
Teeth					Neurological			
Heart					Lymph			
Lungs					Skin			
Abdomen/Hernia					Psychological			
GU					Back			
Rectal					Reflexes			

If abnormal, please provide details: _____

I certify that this is a true record of the examination of the above candidate and that I find said candidate

- ☐ Able to perform the essential job functions without limitation or restriction in accordance with the Franklin County job specification and have reviewed the above health history and have found the candidate free from health impairments that may be a potential risk to the patient/client or which may interfere with the performance of his/her duties, including habituation/addiction to behavior altering substances.

- ☐ Has limiting conditions or restrictions as follows: _____
  If applicable, are there any accommodations which might permit the applicant to perform the essential functions of the job? Yes _____ No _____ If Yes, please describe: _____

- ☐ Not cleared for employment, reasons: _____
  _____

Other comments: _____

Physician's signature below certifies that this is a true record of the examination of the above candidate.

Signature of Examining Physician:	Date:		**Reviewer's Signature at Hiring Authority:**	Date: