

# Communicator Applicant Medical History

## Employing Agency Information Only

This Applicant History and accompanying Medical Examination form is derived partially from the National Emergency Number Association (NENA) Hearing Standards for Public Safety Telecommunicators, the 2015 Job Task Analysis for Telecommunicators, and the National Highway Traffic Safety Administration Emergency Medical Dispatcher (EMD) National Standards Curriculum. It meets the Americans With Disabilities Act (ADA) criteria to identify the Essential Functions/Tasks of the position. A physician developed the medical standards based upon the essential tasks.

Critical and Essential Tasks are located at [www.oregon.gov/dpsst/SC/pages/cjforms.aspx](http://www.oregon.gov/dpsst/SC/pages/cjforms.aspx)

This form is provided to employing agencies that do not have their own Medical Examination sheet. This is not a required document. The F2Ta Final Medical Report and optional waiver are the only forms DPSST requires.

<i>To be completed by applicant</i>		
<b>Applicant Name</b> (Last, First Middle)	<b>Date of Birth</b> (MM/DD/YYYY)	<b>DPSST No.:</b>

1. Do you have any current medical conditions?  Yes  No  
 If so, please list: \_\_\_\_\_

2. Have you had any prior medical conditions that required treatment?  Yes  No  
 If so, please list: \_\_\_\_\_

3. Have you ever had surgery?  Yes  No  
 If so, please list (include year of surgery): \_\_\_\_\_

4. Are you currently taking any medications? (prescribed or over the counter)  Yes  No  
 If so, please list: \_\_\_\_\_

Check if you have had any of the following.	✓	Physician Comments
Headaches requiring treatment	<input type="checkbox"/>	
Concussion or loss of consciousness	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	
Other neurological conditions	<input type="checkbox"/>	
Dizziness / balance problems	<input type="checkbox"/>	
Memory problems	<input type="checkbox"/>	
Depression / anxiety or other psychological conditions	<input type="checkbox"/>	
Vision problems	<input type="checkbox"/>	
Currently wear glasses or contacts	<input type="checkbox"/>	

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<b>Applicant Name</b> (Last, First Middle)	<b>Date of Birth</b> (MM/DD/YYYY)	<b>DPSST No.:</b>
<b>Check if you have had any of the following.</b>	✓	<b>Physician Comments</b>
Eye surgery	<input type="checkbox"/>	
Difficulty driving or seeing at night	<input type="checkbox"/>	
Hearing loss / use of hearing aids	<input type="checkbox"/>	
Ringing in the ears	<input type="checkbox"/>	
Chest pain	<input type="checkbox"/>	
Heart attack	<input type="checkbox"/>	
Irregular / abnormal heart beats	<input type="checkbox"/>	
Heart murmurs	<input type="checkbox"/>	
Unusual shortness of breath	<input type="checkbox"/>	
Persistent diarrhea or constipation	<input type="checkbox"/>	
Blood in your stool	<input type="checkbox"/>	
Blood in your urine	<input type="checkbox"/>	
Coughing up blood	<input type="checkbox"/>	
Liver problems	<input type="checkbox"/>	
Kidney or bladder problems	<input type="checkbox"/>	
Unusual vaginal bleeding (if applicable)	<input type="checkbox"/>	
Hernia(s)	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	
Frequent bloody noses	<input type="checkbox"/>	
Easy bruising	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	
Unexplained weight changes	<input type="checkbox"/>	
Chronic fatigue	<input type="checkbox"/>	
Thyroid problems	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	
Back or neck pain / injuries	<input type="checkbox"/>	
Muscle / ligament / joint injuries	<input type="checkbox"/>	
Broken bones	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	
Illegal drug use	<input type="checkbox"/>	
Alcohol use	<input type="checkbox"/>	
Conviction(s) of driving under the influence	<input type="checkbox"/>	
Attended drug or alcohol rehabilitation	<input type="checkbox"/>	

# Communicator Medical Examination

## Employing Agency Information Only Do Not Send to DPSST

Applicant Name: (Last, First Middle)	DOB: (MM/DD/YYYY)	DPSST No.:
Height: _____ ft. _____ in.	Weight: _____ lbs. / _____ kg.	

**Eyes and Vision**      Eye Exam (EOM, Pupils, etc.):      Normal:  Yes  No

**1. Visual Acuity Standards**

1.1. Corrected vision must be at least 20/30 (Snellen) when tested using both eyes together.

	Right	Left	Both
Uncorrected	R20 /	L20 /	B20 /
Corrected	R20 /	L20 /	B20 /

**2. Color Vision Standards**

- 2.1. Applicant must be able to distinguish red, green, blue, and yellow, as determined by the HRR Test, 4th Edition.
- 2.2. Red or green deficiencies may be acceptable, providing the applicant can read at least nine of the first 13 plates of the Ishihara Test.
- 2.3. Applicant who fails to meet the color vision standard may meet this standard by demonstrating they can correctly discriminate colors via a field test conducted by the employer as approved by the examining physician/surgeon.

HRR Test, 4 <sup>th</sup> Ed.:	Ishihara (if applicable):	Field Test (if applicable):
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Comments:

**Hearing**      Ear Exam (External Canal, Tympanic Membrane, etc.)      Normal:  Yes  No

**3. Hearing Acuity Standards**

Telecommunicators, emergency medical dispatchers or applicants must meet the National Emergency Number Association (NENA) hearing standard NENA-STA-007.2-2014 (June 14, 2014). Audiometric testing shall assess hearing thresholds in each ear, determined using pure tone stimuli via air conduction with test frequencies including 500, 1000, 2000, 3000, 4000, and 6000 Hz.

- 3.1. Hearing thresholds at any evaluated frequency shall not exceed 25 dB HL in either ear. If hearing thresholds exceed 25 dB HL at any evaluated frequency, binaural speech discrimination testing in quiet and noise shall be completed in the sound field.

	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz	Other
Right							
Left							

**Speech Discrimination Testing**      *(if applicable)*

- The minimum acceptable standard of speech discrimination in quiet shall be a score no poorer than 90% correct. The minimum acceptable standard of speech discrimination in noise shall be a score no poorer than 70% correct.
- Use of hearing aids, cochlear implants or enhanced listening devices to achieve the speech discrimination standards is permitted.

✓ Speech discrimination in quiet: \_\_\_\_\_

✓ Speech discrimination in noise: \_\_\_\_\_

Comments:

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Applicant Name:		DOB:	
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#### 4. Medications Standard

The side effects of any prescribed medication must not interfere with the ability of the applicant to perform the critical and essential tasks of the job.

Comments:

#### Laboratory\*

\* To be specified by agency requesting examination

Lab Work	Normal:	Comments
CBC	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chemistry Panel	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Urinalysis / Drug Screen	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	

NOTES: (Provide any additional information to the hiring agency regarding the applicant's job-relevant **functional limitations, reasonable accommodation requirements, work restrictions**, and a description of the **nature and degree of potential risks** posed by the detected medical conditions. Include that information which is necessary and appropriate for the hiring department in making hiring decision.)

I certify that I am a licensed physician or surgeon, have conducted an examination on the above-mentioned applicant, and the information on this form is true and accurate.

Signature	License Number	Date
Printed Name: _____		Phone Number: _____
Address: _____		

Please complete and return this Medical Exam, Applicant Medical History and the Form F2Ta Final Medical Report and optional waiver to the requesting applicant or employing agency