Park Slope Volunteer Ambulance Corps

Physician Medical Clearance Form

As per PSVAC SOP 4-6:
Pre-employment health physicals and screening, as outlined in the NYS EMS Program Policy Statement Number 88-8, shall be required for all members beginning service after January 1, 2009. Members who began active service prior to this date will be offered the opportunity to participate in any agency provided testing or inoculation program.

As per NYS EMS Program Policy Statement Number 88-8:
The pre-employment (membership) physical for EMS Personnel should be a complete physical examination including a medical history. It is further recommended that the exam include a complete vision testing, audiometric testing, a TB purified protein derivative (PPD) skin test (NOT a tine test), and a chest x-ray (if indicated by PPD results).

The physical examination should be conducted by a physician or Physician's Assistant who is familiar with the type of work performed by prehospital providers taking into account the risks and functions associated with the individual's duties and responsibilities.

The health screening portion of the exam should include a determination of the applicant's immunization status for the following diseases: Diphtheria, Tetanus, Polio, Measles, Mumps, Rubella, Hepatitis B, and Chicken Pox. The applicant should be instructed to bring a copy of his/her immunization record to the physical exam.

Applicant Name: _____ Date: _____

Dear Doctor:

A patient of yours has applied for membership to Park Slope Volunteer Ambulance Corps Inc. ("PSVAC") He/She must be in reasonably good health and must not have a medical problem that might be aggravated by the physical and emotional stress associated with an emergency situation.

Physically, your patient must be capable of lifting a 125 pound patient onto a gurney with the assistance of one other person. They must also be capable of lifting and carrying approximately 50 pounds of equipment on their own under various types of conditions. These conditions may include but not be limited to climbing stairs, hillsides and walking measurable distances from a roadside or other site.

Emotionally, your patient must be mentally able to handle the emotional and mental strains associated with an ambulance call. Many times when an ambulance is called, the victim is generally critically ill or injured, increasing the potential stress factor to your patient.

Additionally, your patient must not need to take any controlled substances before or during their membership that may hamper their abilities.

Your patient has been instructed to complete the medical release on the reverse side of this letter. Please feel free to add any additional comments you feel relevant to your patient's ability to function as an EMT. Your comments will be kept confidential and kept as a part of the member's medical file unless a special condition or restriction would require a medical review by our medical director. Thank you for your time and consideration.

Sincerely,

Park Slope Volunteer Ambulance Corps, Membership Committee

HEALTH HISTORY AND PHYSICAL

NAME: (printed)_____ DATE OF BIRTH:_____

HISTORY

Medications taken regularly:_____

Allergies to medications:_____

Any history of: (Explain "yes" answers)

	Y/N		Y/N		Y/N
Heart Disease		Hypertension		Seizures	
Impaired Vision		Impaired Hearing		Thyroid Disease	
Liver Disease		Back Problems		Respiratory Disease	

Other Chronic illness:_____

PHYSICAL EXAM

Height_____ Weight_____ BP_____ P_____ R_____

CHECK IF NORMAL, DESCRIBE IF ABNORMAL:

	General		Skin
	Ears		Eyes
	Nose/Mouth		Neck/Thyroid
	Heart		Chest/Lungs
	Abdomen		Extremities
	Back		Mental Status
	Neuro		

Comments:

I determine that, in my opinion, he/she is free from any physical or mental health impairment which is of potential risk to patients and personnel or might interfere with the performance of his/her duties to include the habitation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances, which might alter the individual's behavior. I also verify the immunization information (unless individually signed by another health care professional).

_____ _____

Signature of Health Care Practitioner _____

_____

Date: _____ **Print** name & address of Practitioner

IMMUNIZATION RECORD

NAME: (printed)_____ DATE OF BIRTH:_____

ALL IMMUNIZATIONS ADMINISTERED MUST BE SIGNED BY A HEALTH CARE PROVIDER, VERIFYING THE ADMINISTRATION.

IMMUNIZATION	DATE	ADMINISTERED/VERIFIED BY:
MMR *(MEASLES/MUMPS/RUBELLA) 1ST DOSE*		
2ND DOSE		
RUBEOLA *(PLAIN MEASLES) 1ST DOSE*		
2ND DOSE		
DIAGNOSED DISEASE		
RUBELLA *(GERMAN MEASLES) 1 DOSE*		
PPD *(MANTOUX SKIN TEST)* *PLANTED*		
READING MM/INDURATION		
HEPATITIS B *1ST DOSE (DAY 0)*		
2ND DOSE (DAY 30)		
3RD DOSE (DAY 180)		
HEPATITIS B REFUSAL		*SIGNATURE*
TETANUS DIPHTHERIA		If vaccine limited by CDC ruling, practitioner please sign and date here _____
VARICELLA (CHICKEN POX) *1ST DOSE*		
2ND DOSE		
OR *DIAGNOSED DISEASE*		

OR **LABORATORY TESTS** ***MUST PROVIDE COPY OF LAB REPORT***

TEST	DATE	READING
MUMPS		
RUBELLA		
RUBEOLA		
HEPATITIS B		
VARICELLA		

Physician's Statement of Fitness

To be completed by Physician:

The above named patient is now or has previously been in my care. I have reviewed this document and am aware of the physical and emotional stress involved in volunteering as an EMT. In my professional opinion, the above named patient is capable of participating as a full member of Park Slope Volunteer Ambulance Corps Inc.

_____ _____

Physician's Signature Date

Comments:_____

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