FORM F-2a

COMMISSION ON LAW ENFORCEMENT STANDARDS AND TRAINING

MEDICAL HISTORY QUESTIONNAIRE

This Box To Be Completed By The Employing Agency:

Name: _____
First Middle Last

Address:_____

You are to report to: _____

Address: _____

At _____ o'clock _____
Mo. Day Yr.

with this questionnaire completed.

TO THE APPLICANT:

A Medical Examination is required by the Commission on Law Enforcement Standards & Training. Your cooperation in filling in this questionnaire as completely as possible will expedite the evaluation and avoid delay.

Instructions to Applicants: Complete this form prior to your physical examination and give the original to the employment agency and a copy to the examining physician and psychological examiner at the time of examination. Answer all questions completely and accurately.

Applicant's Name (Last, First, Middle)		Address
Date of Birth	Age	Current Occupation

SECTION A HAVE YOU EVER OR DO YOU NOW HAVE ANY OF THE FOLLOWING? FOR "YES" ANSWERS, SUPPLY FULL DETAILS IN SECTION B ON THE REVERSE SIDE. IF THE CONDITION REQUIRED HOSPITALIZATION, CHECK THE CORRESPONDING BOX.

CONDITION	NO	YES	HOSP		NO	YES	HOSP
1. HEAD INJURY				24. SENSITIVITY TO DUST			
2. BACK TROUBLE OR BACK PAIN				25. OTHER ALLERGIES			
3. ANY DEFECT OF BONES OR JOINTS INCLUDING AMPUTATIONS, DISLOCATIONS, BROKEN BONES				26. FREQUENT COLDS			
4. LAMENESS				27. CANCER OR MALIGNANCY			
5. RHEUMATISM OR ARTHRITIS				28. TUMOR, GROWTH OR CYST			
6. TRICK OR LOCKED KNEE/KNEE INJURY				29. ANY COMPLICATIONS FROM CHILDHOOD DISEASES			
7. FOOT TROUBLE				30. POLIO			
8. EYE INJURY, SURGERY, DISEASE				31. RHEUMATIC FEVER			
9. HAVE YOU EVER WORN GLASSES/CONTACT LENS?				32. HEART TROUBLE, INCLUDING CIRCULATORY			
10. HARD OF HEARING OR HEARING PROBLEMS				33. HIGH OR LOW BLOOD PRESSURE			
11. WORN A HEARING AID				34. VARICOSE VEINS			
12. HEADACHES				35. PERNICIOUS ANEMIA, LEUKEMIA, OR OTHER BLOOD DISORDER OR AILMENT			
13. MENTAL ILLNESS OF THE NERVOUS SYSTEM				36. HEPATITIS, JAUNDICE OR OTHER LIVER AILMENTS			
14. ADDICTION TO DRUGS OR ALCOHOL				37. DIABETES OR SUGAR IN URINE			
15. FAINTING OR DIZZY SPELLS				38. ULCERS OR OTHER STOMACH TROUBLE			
16. EPILEPSY OR FITS				39. COLITIS			
17. ANY DISORDER OF THE NERVOUS SYSTEM				40. GALL BLADDER TROUBLE			
18. TUBERCULOSIS OR OTHER LUNG TROUBLE				41. KIDNEY/BLADDER TROUBLE			
19. SHORTNESS OF BREATH				42. PILES OR HEMORRHOIDS			
20. ASTHMA				43. RUPTURE OR HERNIA			
21. BRONCHITIS				44. MONONUCLEOSIS			
22. POISON OAK OR POISON IVY							
23. SKIN TROUBLE							

	NO	YES
45. HAVE YOU EVER HAD OR BEEN ADVISED TO HAVE AN OPERATION? IF "YES", GIVE THE NATURE AND DATE(S) AND PLACE(S) OF OPERATION(S).		
46. HAVE YOU EVER BEEN A PATIENT (COMMITTED OR VOLUNTARY) IN A MENTAL HOSPITAL? IF "YES", GIVE REASONS, DATE(S) AND PLACE(S).		
CONTINUE ON REVERSE SIDE FOR "YES" ANSWERS. SUPPLY DETAILS IN SECTION B ON REVERSE SIDE.		

REVISED 08/15

SECTION A CONTINUED	NO	YES
47. HAVE YOU HAD ANY OTHER ILLNESS, INJURY, OR PHYSICAL CONDITION NOT NAMED ABOVE, OTHER THAN CHILDHOOD DISEASES OR MINOR ILLNESSES? IF "YES", EXPLAIN:		
48. HAVE YOU HAD AN INJURY WITHIN THE LAST 5 YEARS WHICH CAUSED YOU TO LOSE TIME FROM WORK?		
49. HAVE YOU EVER BEEN DENIED EMPLOYMENT OR INSURANCE FOR MEDICAL REASONS?		
50. HAVE YOU EVER BEEN DEFERRED FROM MILITARY SERVICE FOR MEDICAL, EMOTIONAL, OR HEALTH REASONS?		
51. HAVE YOU EVER BEEN DISCHARGED OR RELEASED FROM EMPLOYMENT OR FROM THE ARMED FORCES FOR MEDICAL, EMOTIONAL, OR HEALTH REASONS?		
52. HAVE YOU EVER RECEIVED OR APPLIED FOR PENSION OR COMPENSATION FOR DISABILITY OR INJURY?		
53. ARE YOU PRESENTLY UNDER THE DOCTOR'S CARE FOR ANY CONDITION?		
54. HAVE YOU TAKEN MEDICATION WITHIN THE LAST 12 MONTHS FOR ANY REASON? IF "YES", EXPLAIN.		
55. HAVE YOU EVER USED MARIJUANA OR OTHER NON-PRESCRIPTION DRUGS? (IF "YES", EXPLAIN WHEN AND DURATION OF USE IN SECTION B BELOW)		
56. DO YOU OR HAVE YOU EVER HAD ANY PHYSICAL OR EMOTIONAL LIMITATIONS? IF "YES", EXPLAIN.		

PHYSICIANS CONSULTED (For above items checked "Yes". Identify Item No.)

Item	Physician's Name	Address (No., Street, City, State)

SECTION B	WRITE YOUR OWN ACCOUNT AND EXPLAIN ALL ITEMS ANSWERED "YES" IN THIS QUESTIONNAIRE. IDENTIFY ITEM NUMBER, INCLUDE DIAGNOSIS, DATE OF ONSET, AND YOUR PRESENT CONDITION. CONTINUE ON 81/2 X 11 SHEETS OF PAPER AND ATTACH

PENALTY

ANY FALSIFICATION, WITHHOLDING OR FAILURE TO ANSWER ALL QUESTIONS COMPLETELY AND ACCURATELY MAY CAUSE FORFEITURE OF ALL RIGHTS TO THIS EMPLOYMENT.

CERTIFICATION

I HEREBY CERTIFY THAT THERE ARE NO WILLFUL MISREPRESENTATIONS, OMISSIONS OR FALSIFICATIONS IN THE FOREGOING STATEMENTS AND ANSWERS TO QUESTIONS, AND THAT ALL STATEMENTS AND ANSWERS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE OF APPLICANT (Sign in Ink) X	DATE SIGNED