Licensee Medical Condition Declaration (**L-2**)

Pre-Placement/Wellness Assessment form

Medical History form

Work History form

Read Carefully before signing form

THIS SHOULD BE SCHEDULED AS SOON AS POSSIBLE

Contact Hunt Regional Clinic to set up the appointment
(No Walk-ins)
903-408-1940
3206 Interstate 30 W., Suite B
Greenville, TX. 75402

Take the completed (**L-2**) form with supplementary forms and a copy of the **Authority to Release Information** form to the Physical.

The cost is approximately $148

TEXAS COMMISSION ON LAW ENFORCEMENT
6330 E. Highway 290, STE. 200, Austin, Texas 78723-1035
Phone: (512) 936-7700
http://www.tcole.texas.gov

LICENSEE MEDICAL CONDITION DECLARATION (L-2) Commission Rule §217.1, 217.7

INDIVIDUAL INFORMATION

1. TCOLE PID	2. Last Name	3. First Name	4. M.I.	5. Suffix (Jr., etc.)

6. Home Mailing Address	7. City	8. State	9. Zip Code

APPOINTMENT (Do not check if student is in an academy)

10. ☐ Initial Appointment, Never Licensed ☐ License holder with more than a 180 day break in service

11. ☐ Peace Officer ☐ Reserve Officer ☐ County Jailer ☐ Telecommunicator

DEPARTMENT / ACADEMY INFORMATION

An agency hiring a person for whom a license is sought shall select the examining physician. The hiring agency shall maintain a copy of the report on file in a format readily accessible to the commission.

12. TCOLE Number	13. Appointing Agency or Academy

Attention Examining Professional: The above information must be completed by the requesting agency prior to the examining professional completing and signing the L-2 form.
INITIAL APPOINTMENTS: Peace Officer (both exams), County Jailer (both exams), Telecommunicator (drug screen only).
MORE THAN 180 day break in service: Peace Officer, County Jailer, and Telecommunicator: Drug Screen ONLY.

I certify that I have completed my examination of the examinee, on this date and determine the examinee is found:

☐ **MEDICAL EXAM** - To be physically sound and free from any defect which may adversely affect the performance of duty appropriate to the type of license sought.

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner (State License # not required)

14. Name (type or print)	15. License No

16. Street Address

17. City	18. State	19. Zip Code	20. Phone Number

21. Date of Examination	22. Signature	23. Date

I certify that I have completed my examination of the examinee, on this date and determine the examinee is found:

☐ **DRUG SCREEN** - To show no trace of drug dependency or illegal drug use after a physical examination, blood test or other medical test.

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner (State License # not required) ☐ DoT Provider

24. Name (type or print)	25. License No

26. Street Address

27. City	28. State	29. Zip Code	30. Phone Number

31. Date of Examination	32. Signature	33. Date

THIS DECLARATION IS NOT PUBLIC INFORMATION PER TEXAS OCCUPATIONS CODE 1701.306. VALID FOR 180 DAYS FROM GRADUATION DATE OF ACADEMY, IF ACCEPTED BY APPOINTING AGENCY OR VALID FOR 180 DAYS FROM DATE SIGNED UNLESS WITHDRAWN OR INVALIDATED. MUST BE SIGNED BY A **LICENSED PHYSICIAN, NURSE PRACTITIONER, or PHYSICIANS ASSISTANT WITH A VALID PHYSICIANS ID, or in the case of a DoT drug screen only, authorized DoT personnel.**

Hunt Regional Occupational Health

The health of your employees is our business

Pre-Placement / Wellness Assessment

Greenville 903-408-1940

Position Offered:

INSTRUCTIONS

Medical Evaluation assists in developing data about each job applicant's medical history. Accurate and up-to-date information is essential to providing effective health maintenance programs. Please answer the following questions as completely as you can. The information provided will become a part of your permanent medical record and will be held in strict confidence.

▷ PLEASE PRINT CLEARLY ◁

Name (Last, First, MI):	Age:	Sex:	Race:	Date of Birth

Social Security Number:	Personal Physician (Last, First, MI):	Physician's Phone Number

Current Medications: _____

_____

Medication Allergies:

_____

_____

Family Violence Exposure Questions:

1. Is someone hurting or threatening you in your home? ☐ Yes ☐ No
2. Are you afraid in your home? ☐ Yes ☐ No
3. Are there any concerns you would like to express at this time? ☐ Yes ☐ No

EMERGENCY

Emergency Contact: _____

Relationship (e.g., mother, spouse, friend): _____

Day Phone: (___) _____ Evening Phone: (___) _____

MEDICAL HISTORY

Please check the appropriate box if you have ever had or now have any of the following conditions. If "Yes", use number with explanation at bottom of page. Attach additional pages if required.

Do you have or have you ever had?	Yes	No
1. Reactions to Chemicals		
2. Reactions to Medicines		
3. Reactions to Oils		
4. Skin Rashes or Dermatitis		

Do you have or have you ever had?	Yes	No
5. Anesthesia		
6. Bronchitis or Asthma		
7. Tobacco usage or Smoked		
a. # of packs per day		
b. How many years		
8. Emphysema or bleeding		
9. Hay fever		
10. Shortness of breath		
11. Tightness of chest		
12. Tuberculosis		

Do you have or have you ever had?	Yes	No
13. Chest Pain		
14. Heart Attack		
15. Heart Disease or Blocked Arteries		
16. Heart Murmur		
17. High Blood Pressure		
18. Phlebitis		
19. Rheumatic Fever		
20. Stroke or Aneurysm		
21. Swelling of Ankles		
22. Varicose Veins		

Do you have or have you ever had?	Yes	No
23. Changes in Bowel Habits		
24. Constipation		
25. Frequent Diarrhea		
26. Frequent Indigestion		
27. Frequent Nausea		
28. Gall Bladder Disease		
29. Hemorrhoids		
30. Hepatitis		
31. Hernia		
32. Liver Disease or Cancer		
33. Stomach Ulcer		
34. Blood in Stool		

Do you have or have you ever had?	Yes	No
35. Convulsions		
36. Depression		
37. Double Vision/ Dizziness		
38. Epilepsy		
39. Fainting/ Claustrophobia		
40. Migraine Headaches		
41. Numbness of Hand/Feet		
42. Paralysis/ Garbled Speech		
43. Headaches/ Forgetfulness		

Do you have or have you ever had?	Yes	No
44. Amputation		
45. Back Injury		
46. Back Pain on Lifting		
47. Back Surgery		
48. Back Condition		
49. Shoulder Pain		
50. Fracture of Bones		
51. Knee Injury		
52. Neck Injury		
53. Rheumatism		
54. Swollen or Painful Joints		
55. Flat or Aching Feet		

Do you have or have you ever had?	Yes	No
56. Are you color blind?		
57. Do you wear contact lens?		
58. Do you wear glasses?		
a. for Reading		
b. for Distance		
59. Blindness		
60. Blurry Vision		
61. Cataracts		
62. Detached Retina		
63. Eye Injury		
64. Glaucoma		

EARS

Do you have or have you ever had?	Yes	No
65. Difficulty in hearing		
66. Ear surgery		
67. Ear trouble		

NOSE

Do you have or have you ever had?	Yes	No
68. Loss of smell		
69. Nose bleeds		
70. Nose injuries		
71. Sinus infections		

Do you have or have you ever had?	Yes	No
72. Bladder Problems		
73. Blood in Urine		
74. Kidney Problem		
75. Urinary Infections or Frequent Urination		
76. Kidney Stones		

Do you have or have you ever had?	Yes	No
77. Diabetes / Sugar in Urine		
78. Low Blood Sugar		
79. Thyroid Disease		
a. Benign		
b. Cancerous		

Do you have or have you ever had?	Yes	No
80. Anemia, Sickle-Cell or Glucose-6-Phosphate		
81. Hemophilia		
82. Bleed Easily		

Do you have or have you ever had?	Yes	No
83. Malaria		
84. Jaundice		
85. Profuse Sweats		

NUMBER	DATE	EXPLANATION

WORK HISTORY

Have you ever worked in one of the following occupations or industry?

	Yes	No
86. Assembly Worker	____	____
87. Chemical, Aerosol, Polyurethane or Pharmaceuticals Industries or Furniture Shipping	____	____
88. Cotton Mill	____	____
89. Dry Cleaning	____	____
90. Equipment Maintenance	____	____
91. Farming	____	____
92. Fertilizer Plant	____	____
93. Insulation Removing/Installing	____	____
94. Laser Technology	____	____
95. Mechanic	____	____
96. Microwave/ Radio Frequency Technology	____	____
97. Painter	____	____
98. Petroleum Industry	____	____
99. Plating	____	____
100. Radioactive Material Handler	____	____
101. Radiograhpher/X-ray Tech	____	____
102. Sand Blasted	____	____
103. Soldering	____	____
104. Steel Mill	____	____
105. Welder/Brazing	____	____

Have you ever worked with any of the following substances or other potentially hazardous materials?

	Yes	No
106. Asbestos/Fiberglass	____	____
107. Arsenic, Nickel, Cadmium, Chromate's	____	____
108. Benzene/Solvents	____	____
109. Beryllium	____	____
110. Brake Linings	____	____
111. Cotton/Flax	____	____
112. Excessive Noise	____	____
113. Formaldehyde (Aldehydes)	____	____
114. Isocyanates (TDI, MID, HDI)	____	____
115. Lead, Mercury or Heavy Metals	____	____
116. Methylene Chlorides, Chloroform Solvents	____	____
117. Nickel Carbonyl	____	____
118. Pesticides, Insecticides or Herbicides	____	____
119. Silica (Sand, Water)	____	____
120. Vinyl Chloride (PVC)	____	____
121. Dichloromethane, CH2C12	____	____
122. Methylene Dichloride	____	____
123. Other _____	____	____
124. Other _____	____	____
125. Other _____	____	____
	____	____

Have you ever?

	Yes	No
126. Been required to wear or had difficulty wearing a respirator while working	____	____
127. Been required to wear hearing protection while working	____	____
128. Been a patient in any type of hospital	____	____
129. Had or any member of your family had or have a Chronic Disease or Disability (Heart Disease, Lung Disease, Diabetes, Stroke, Hypertension, etc.)	____	____
130. Had any major surgeries (including By-pass surgery)	____	____

IMMUNIZATIONS

131. Date of last Tetanus/Diptheria Booster _____
132. Other Immunizations:

DATE	IMMUNIZATION

	Yes	No
133. Do you have physical defects or partial disability	____	____

NUMBER	DATE	EXPLANATION

READ CAREFULLY BEFORE SIGNING

I hereby certify that all answers given by me on this form are true and complete. I agree that any misrepresentation or omission of facts by me as called for in this form is just cause for dismissal. I hereby authorize release of any medical information concerning my past or present condition by any practitioner, hospital or former employer. I hereby authorize HROH to release the information obtained in this assessment to my employer or person paying for this assessment.

Signature of Applicant _____ Date _____

Company _____ Job Applied For _____

FOR EXAMINER USE ONLY

Pulse	B/P	Respirations	Temperature	Height	Weight	DOB	Age	LMP

Vision

Uncorrected	R 20/	L 20/	Both 20/
Corrected	R 20/	L 20/	Both 20/
Corrected with	[ ] Contact Lens		[ ] Glasses

Color Vision
[ ] Normal
[ ] Abnormal

Peripheral
Right - WNL [ ] Yes [ ] No
Left - WNL [ ] Yes [ ] No

Depth Perception - WNL [ ] Yes [ ] No

Hearing Type of hearing test performed: [ ] Audiogram [ ] Whisper Test

Right Ear [ ] WNL [ ] Not WNL Left Ear [ ] WNL [ ] Not WNL

	Normal	Abnormal		Normal	Abnormal
Skin - Scars			G. U.		
Head - Neck			Hernia		
Eyes			Joints		
Ears			Extremities		
Nose			Neuralgic		
Throat - Mouth			Gait		
Thyroid			**Lumbar Region**		
Teeth - Gums			Posture		
Thorax - Lungs			Deformities		
Heart			Mobility		
Abdomen			Muscle Tone		

LABORATORY WORK OBTAINED

Dipstick UA

Remarks: _____

Date: _____ Printed Name or Typed Name of Examiner: _____

Signature of Examiner: _____

Please indicate Certification and/or License of Examiner by Circling Appropriate Title: MD DO FNP PA RN