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 employing 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							
2. BACK TROUBLE OR BACK PAIN				22. ALLERGIES			
3. ANY DEFECT OF BONES OR JOINTS INCLUDING AMPUTATIONS, DISLOCATIONS, BROKEN BONES				23. FREQUENT COLDS			
4. PARALYSIS				24. CANCER OR MALIGNANCY			
5. RHEUMATISM OR ARTHRITIS				25. TUMOR, GROWTH OR CYST			
6. KNEE INJURY				26. ANY COMPLICATIONS FROM CHILDHOOD DISEASES			
7. FOOT TROUBLE				27. POLIO			
8. EYE INJURY, SURGERY, DISEASE				28. RHEUMATIC FEVER			
9. HAVE YOU EVER WORN GLASSES/CONTACT LENSES?				29. HEART TROUBLE, INCLUDING CIRCULATORY			
10. HARD OF HEARING, HEARING PROBLEMS, OR WORN A HEARING AID				30. HIGH OR LOW BLOOD PRESSURE			
11. HEAT STROKE OR HEAT RELATED INJURY				31. VARICOSE VEINS			
12. HEADACHES				32. PERNICIOUS ANEMIA, LEUKEMIA, OR OTHER BLOOD DISORDER OR AILMENT			
13. MENTAL ILLNESS				33. HEPATITIS, JAUNDICE OR OTHER LIVER AILMENTS			
14. ADDICTION TO DRUGS OR ALCOHOL				34. DIABETES OR EXCESSIVE SUGAR IN URINE			
15. FAINTING OR DIZZY SPELLS				35. ULCERS OR OTHER STOMACH TROUBLE			
16. EPILEPSY OR SEIZURES				36. COLITIS			
17. ANY DISORDER OF THE NERVOUS SYSTEM				37. GALL BLADDER TROUBLE			
18. TUBERCULOSIS OR OTHER LUNG TROUBLE				38. KIDNEY/BLADDER TROUBLE			
19. SHORTNESS OF BREATH				39. RUPTURE OR HERNIA			
20. ASTHMA				40. MONONUCLEOSIS			
21. BRONCHITIS							

41. 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).	NO	YES
42. 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.		

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SECTION A CONTINUED	NO	YES
43. HAVE YOU HAD ANY OTHER ILLNESS, INJURY, OR PHYSICAL CONDITION NOT NAMED ABOVE, OTHER THAN CHILDHOOD DISEASES OR MINOR ILLNESSES? IF "YES", EXPLAIN:		
44. HAVE YOU HAD AN INJURY WITHIN THE LAST 5 YEARS WHICH CAUSED YOU TO LOSE TIME FROM WORK?		
45. HAVE YOU EVER BEEN DENIED EMPLOYMENT OR INSURANCE FOR MEDICAL REASONS?		
46. HAVE YOU EVER BEEN DEFERRED FROM MILITARY SERVICE FOR MEDICAL, EMOTIONAL, OR HEALTH REASONS?		
47. HAVE YOU EVER BEEN DISCHARGED OR RELEASED FROM EMPLOYMENT OR FROM THE ARMED FORCES FOR MEDICAL, EMOTIONAL, OR HEALTH REASONS?		
48. HAVE YOU EVER RECEIVED OR APPLIED FOR PENSION OR COMPENSATION FOR DISABILITY OR INJURY?		
49. ARE YOU PRESENTLY UNDER THE DOCTOR'S CARE FOR ANY CONDITION?		
50. HAVE YOU TAKEN MEDICATION WITHIN THE LAST 12 MONTHS FOR ANY REASON? IF "YES", EXPLAIN.		
51. HAVE YOU EVER USED AN ILLEGAL DRUG OR USED ANY CONTROLLED SUBSTANCE WITHOUT A PRESCRIPTION? (IF "YES", EXPLAIN WHEN AND DURATION OF USE IN SECTION B BELOW)		
52. DO YOU HAVE ANY PHYSICAL OR EMOTIONAL LIMITATIONS THAT INTERFERE WITH YOUR DAILY ACTIVITIES? 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