NORRISTOWN FIRE DEPARTMENT

ANNUAL MEDICAL STATEMENT FOR APPARATUS OPERATORS

This form is designed to provide the Chief a complete history of physical status as of the date indicated without the need for a physical examination. This form shall be completed on an annual basis by all drivers of emergency vehicles. If any of the questions are answered "YES", be sure the answer is fully explained. The Municipality of Norristown reserves the right to have a member who has answered "YES" to any question to provide full documentation as to their fitness to operate borough owned emergency vehicles.

QUESTIONS:

Name: _____

Address: _____

City & State: _____ Zip: _____

Date of Birth: _____

Are you a: ☐ Certified Operator ☐ Operator Candidate

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1. EYESIGHT:

a. Have you lost use of either eye? ☐ Yes ☐ No
b. Is peripheral (side) vision restricted? ☐ Yes ☐ No
c. Are you color blind? ☐ Yes ☐ No
d. Do you have, or have you ever had cataracts? ☐ Yes ☐ No
e. Are actual deficiencies corrected by glasses or contact lenses? ☐ Yes ☐ No
f. Date of last eye examination _____

2. HEARING:

a. Do you have difficulty hearing normal conversation level? ☐ Yes ☐ No
b. Do you use a hearing aid? ☐ Yes ☐ No

3. DIABETES:

a. Have you ever been treated for diabetes? ☐ Yes ☐ No
b. Describe current medication and dosage, if any, and method of administration under "remarks"
c. Date of latest blood sugar test _____

4. HEART:

a. Have you ever been treated for heart disease? ☐ Yes ☐ No
b. Describe condition under "remarks"
c. Do you have a pacemaker? ☐ Yes ☐ No
d. Date of last treatment or check-up _____

5. EPILEPSY:

a. Have you ever been treated for epilepsy? ☐ Yes ☐ No
b. If "Yes", when was you last seizure? _____
c. Describe current medication and dosage, if any, under "remarks"

6. BLOOD PRESSURE:

a. Have you ever been treated for high blood pressure? ☐ Yes ☐ No
b. If "Yes", when were you treated? _____
c. What was your last reading? _____
d. Describe current medication and dosage, if any, under "remarks"

REMARKS:

If any question is answered "YES, give particulars below. For medical histories, underline the item and identify by referring to question number and letter. Give dates, symptoms, duration, treatment results, names and addresses of doctors, hospitals, etc. Attach additional paper and forms as necessary.

QUESTIONS:

7. LIMBS

a. Have you lost an arm or leg? ☐ Yes ☐ No
b. Have you lost significant use of an arm or a leg? ☐ Yes ☐ No
c. Does vehicle have special controls? ☐ Yes ☐ No
d. If "Yes" to any of the above, describe under "remarks"

8. MISCELLANEOUS:

a. Have you ever had, or been treated for convulsions? ☐ Yes ☐ No
b. If "yes", give date of last treatment and describe current medication and dosage, if any, under "remarks"
c. Have you ever had any Fainting Spells? ☐ Yes ☐ No
d. If "yes", give date of last treatment and describe current medication and dosage, if any, under "remarks"
e. Have you ever had, or been treated for loss of equilibrium? ☐ Yes ☐ No
f. If "yes", give date of last treatment and describe current medication and dosage, if any, under "remarks
g. Have you ever been treated for alcohol or drug abuse? ☐ Yes ☐ No
h. If "yes", give date of last treatment and describe current medication and dosage, if any, under "remarks
i. Have you ever been treated for mental illness? ☐ Yes ☐ No
j. If "yes", give date of last treatment and describe current medication and dosage, if any, under "remarks

WHAT IS THE DATE OF YOU LAST PHYSICAL EXAMINATION? _____

ARE THERE ANY RESTRICTIONS POSTED ON YOU VEHICLE OPERATOR'S LICENSE? ☐ Yes ☐ No

ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION NOT MENTIONED ABOVE WHICH MAY AFFECT YOU ABILITY TO OPERATE A EMERGENCY VEHICLE? ☐ Yes ☐ No

PHONE: _____

REMARKS:

The answers to the above are complete, accurate and true to the best of my knowledge.

_____ _____

SIGNATURE OF PERSON NAMED ABOVE DATE

Norristown Fire Department
235 East Airy Street
Norristown, Pennsylvania 19401

Drivers Certification

Name						Date	
Address				Unit #		FD ID #	
City		State		Zip		P/F	

1	Present drivers card and state drivers license *	Y	N	NA
2	Check Tires	Y	N	NA
3	Check lighting	Y	N	NA
4	Check oil and fluid levels	Y	N	NA
5	Check adjustment of mirrors	Y	N	NA
6	Check wipers	Y	N	NA
7	Fasten seat belt	Y	N	NA
8	Release parking brake	Y	N	NA
9	Uses turn signal	Y	N	NA
10	Both hands on wheel	Y	N	NA
11	Uses mirrors while driving	Y	N	NA
12	Stays in lane	Y	N	NA
13	Drives the speed limit *	Y	N	NA
14	Makes complete stops at stops signs *	Y	N	NA
15	Obeys traffic signals	Y	N	NA
16	Uses help when backing up	Y	N	NA
17	Uses wheel chocks when parking	Y	N	NA
18	Put engine in pump *	Y	N	NA
19	Circulate water through pump	Y	N	NA
20	Know how to calculate friction loss	Y	N	NA
21	Can transfer from tank to Hydrant	Y	N	NA
22	Know minimum compound pressure	Y	N	NA
23	Know the pressure for supplying another apparatus	Y	N	NA
24	Know the different pressure for smooth bore or task force tip	Y	N	NA
25	Able to put Aerial into operation *	Y	N	NA
26	Know the safety distance from electrical wires	Y	N	NA
27	Able to put permanently mounted equipment into service (generator, lights, Hurst tools, cascade)*	Y	N	NA
28	Know what equipment is on apparatus	Y	N	NA

* Notes automatic failure.

Examiner Signature_____