UNIVERSITY OF CENTRAL FLORIDA
EMPLOYMENT RELATED HISTORY

TO EXAMINING PHYSICIANS: This evaluation is requested to assess the applicant's ability to fulfill the minimum physical requirements of the attached job description. It is in the best interests of the applicant, the University of Central Florida, and the State of Florida that you carefully note any and all abnormalities.

Name of applicant_____ Date of Birth _____
Position applied for _____
*Department and Dept Acct. # _____

*Department account number listed will be responsible for exam costs. Exam will not be conducted without account #.

Have you ever: (please mark YES or NO with "X")

	YES	NO		YES	NO
Received a pension for disability			Received Worker's Compensation		
Been refused life insurance for health reasons			Been refused a driver's license for health reasons		
Been refused employment for health reasons			Been forced to give up a job for health reasons		
Been discharged from the military for health reasons			Been rejected for military service for health reasons		
Been made ill by your work environment			Worked w/radio-active material		
Had swelling of legs, ankles or feet			Had frequent nausea, vomiting, or diarrhea		
Had an operation or been advised to have an operation			Injured your back or had back pain (chronic)		

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or individual's family member receiving assistive reproductive services

Applicant Name_____

	YES	NO		YES	NO
Worked with asbestos or worked in a dusty trade	_____	_____	Had difficulty urinating or had blood in urine or stool	_____	_____
Needed glasses to read or see for distance	_____	_____	Worn contact lenses	_____	_____
Had chronic skin problems, skin rash, or Eczema	_____	_____	Had heart trouble, chest pains or Angina	_____	_____
Had a ruptured disk	_____	_____	Worn a back brace or a truss	_____	_____
Been seriously injured or ill	_____	_____	Taken medicine regularly (list below)	_____	_____
Had Varicose Veins/Phlebitis	_____	_____	Had convulsions/Epilepsy	_____	_____
Had drug reactions	_____	_____	Had allergies	_____	_____
Had hearing loss	_____	_____	Used a hearing aid	_____	_____
Worn a knee brace	_____	_____	Had Tuberculosis	_____	_____
Had Diabetes	_____	_____	Had Cancer	_____	_____
Had previous toxic exposure	_____	_____	Had high blood pressure	_____	_____
Had paralysis	_____	_____	Had joint pains or arthritis	_____	_____
Had Kidney Disease	_____	_____	Had fainting spells or dizziness	_____	_____
Had Asthma	_____	_____	Had headaches (frequent)	_____	_____
Had Rheumatic Fever	_____	_____	Had a cough (frequent or chronic)	_____	_____
Had a head injury	_____	_____	Had an abnormal electrocardiogram	_____	_____
Had Hepatitis	_____	_____	Had dental problems	_____	_____
Had stomach ulcer	_____	_____	Had shortness of breath	_____	_____
Smoke or chew tobacco	_____	_____			

Explanation of **Yes** answers**:** _____

_____

I declare that all information provided by me, the applicant, is true to the best of my knowledge and hereby give permission to the examining physician to release any of the information listed on this exam form to the proper authorities at the University of Central Florida. I understand that any false information or misstatement of facts may result in my disqualification as an applicant or grounds for termination of employment.

Signature of Applicant_____ **Date**_____

Form B

University of Central Florida

Employment Related Physical Form

PATIENT NAME: _____ Date of Birth _____

	Normal	Abnormal
Vital signs: HR:_____ BP:_____ Temp:_____ Hgt:_____ Wgt:_____ BMI:_____	_____	_____
Eyes: Vision Exam: Near: R 20/_____ L 20/_____ , Far: R 20/_____ L 20/_____	_____	_____
Color perception: _____ EOM: _____ Conjunctiva: _____ Pupils: _____	_____	_____
Ears/ Hearing: Canals, tympanic membranes, decreased auditory acuity	_____	_____
Nose & Sinuses: Deformity, obstruction, infection, signs of allergy	_____	_____
Oral Exam: Enlarged tonsils, pharynx, tonsils, gums, dentition, mucous, tongue	_____	_____
Neck Thyroid: Enlargement, adenopathy, masses	_____	_____
Thorax: Inadequate expansion, deformity	_____	_____
Heart: Enlargement, arrhythmia, mummers, abnormal tones	_____	_____
Blood Vessels: Bruits, decreased pulses	_____	_____
Lungs: Rales, ronchi, wheezing, dullness, infection	_____	_____
Abdomen: Organ enlargement, inguinal hernia, ventral hernia	_____	_____
Back: Deformity, weakness, decreased ROM	_____	_____
Extremities: Deformity, amputation, limitation of motion, infection, varicose veins, lymph nodes Edema	_____	_____
Skin: Disfiguring defects or scars, infection, lesions, rashes, tattoos	_____	_____
Neurologic: Abnormal reflexes, sensation; strength, coordination, gait, station	_____	_____

Physicians Signature:_____ **Date:**_____

Office Address: _____

Florida License #: _____

Revised 6/2020

Form C

University of Central Florida

Employment Related Clearance Form

Applicant Name_____ Date of Birth _____

Physician Statement: I find this applicant to be **ACCEPTABLE/ NOT ACCEPTABLE** for employment in the position for which they applied**.**

If not acceptable: ___ Decision deferred pending further medical information

___ Applicant doesn't meet the essential job functions

___ Acceptable but applicant would need the following accommodations/restrictions:

_____

_____

_____

Physicians Signature:_____ **Date:**_____

Office Address:_____

Florida License #: _____

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Form D

University of Central Florida

Identified Medical Issue Notification

Applicant/Employee Name: _____ Date of Birth _____

During your appointment today you were found to have the following medical issue(s) not related to your work:

_____

_____

_____

This medical issue should be followed emergently/urgently/within next few weeks with a healthcare provider of your choice.

Note: You will be responsible for expenses related to the evaluation and management of the identified medical issues.

Physician Signature _____ Date _____

Applicant Signature _____ Date _____

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Form E

University of Central Florida

Employment Related Medical Information Request

Applicant/Employee Name: _____ Date of Birth _____

In order to complete your employment related medical evaluation, please provide the following medical information:

_____

_____

_____

This medical information is requested to be received before the following date _____ to complete your evaluation. Requested information may be sent by secure fax to UCF SHS Health Information Management at 407-823-3359.

Physicians Signature:_____ **Date:**_____

Office Address:_____

Florida License #:_____

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