STATE OF CALIFORNIA
DEPARTMENT OF CORRECTIONS AND REHABILITATION

OFFICE OF PEACE OFFICER SELECTION
PRE-EMPLOYMENT MEDICAL UNIT

PEACE OFFICER HEALTH QUESTIONNAIRE

OPOS 13B-PEM (06/08) Forms are not to be taken to a clinic until the medical provider has scheduled an evaluation.

PART A (Please Print)

NAME OF APPLICANT *(Last)*	*(First)*	*(Middle)*
ADDRESS *(Number and Street)*	*City*	*State* California	*Zip Code*	DAY TIME PHONE
SOCIAL SECURITY NUMBER (Optional – See Privacy Notice on Reverse Side)	BIRTHDATE *(Month, Date Year)*	GENDER ☐ MALE ☐ FEMALE

"Yes" answers to questions in parts B and C must be explained in Part D on the back of this form.

PART B

1. Do you have a physical or mental impairment that limits one or more of the following major life activities?

	YES	NO		YES	NO		YES	NO
a. Caring for yourself	○	○	d. Seeing	○	○	g. Breathing	○	○
b. Performing manual tasks	○	○	e. Hearing	○	○	h. Learning	○	○
c. Walking	○	○	f. Speaking	○	○	i. Working	○	○

2. Do you have any physical or mental impairment that limits your ability to:

	YES	NO
a. Perform any of the physically demanding tasks (listed on the enclosed "ESSENTIAL FUNCTIONS / PHYSICALLY DEMANDING TASKS")	○	○
b. Observe or become aware of activities around you?	○	○
c. Remain alert and in control of your faculties?	○	○

3. Do you currently have or have ever had a handicap placard issued in your name by the Department of Motor Vehicles (in California or any other state in which you resided)? If yes, please provide the dates, type of placard (temporary or permanent) and purpose. ☐ YES ☐ NO

PART C *Do you have or have you ever had the following:*

ITEM	YES	NO
HAVE YOU EVER HAD ANY OF THE FOLLOWING INJURIES/CONDITIONS		
1. Head trauma (within the past ten years)	○	○
2. Migraine headaches (within the past ten years)	○	○
3. Fainting spells/blackouts (within the past ten years)	○	○
4. Convulsions, seizures or loss of consciousness	○	○
5. Cancer	○	○
6. Diabetes	○	○
7. High or low blood pressure	○	○
8. Heart problems, coronary artery disease, or circulatory disease	○	○
9. Defect of bones or joints, including amputations, missing finger(s), toe(s), hand, foot, arm or leg	○	○
10. Anemia (including sickle cell) leukemia, or other blood disorders	○	○
11. Hepatitis C	○	○
12. Rheumatic fever or residuals of poliomyelitis	○	○
13. Recurrent dizziness	○	○
14. Severe headaches (debilitating)	○	○
15. Severe sinus trouble (debilitating)	○	○
16. Allergy/hay fever or severe skin condition (debilitating)	○	○
17. Broken bones or dislocations	○	○
18. Rheumatism, arthritis, or bursitis (swelling of the joints)	○	○
19. Back pain, injury, or any chronic back problems	○	○
20. Fracture, surgery or other problems with hands, elbows, or shoulders	○	○
21. Fracture, surgery or other problems with hips, knees, ankles, or feet	○	○

ITEM	YES	NO
22. Surgery, physical therapy, or hospitalization	○	○
23. Rupture or hemia	○	○
24. Stomach ulcer or bowel problems (colitis, irritable bowel syndrome, or rectal bleeding)	○	○
25. Gall bladder trouble, kidney problems, chronic bladder problems or blood in urine	○	○
26. Lung or respiratory problems, including asthma chronic bronchitis, shortness of breath, or active tuberculosis (TB)	○	○
27. Sleep apnea or difficulty staying awake and alert	○	○
28. Thyroid Disorder	○	○
29. Dyslexia or learning disability	○	○
30. History of drug or alcohol addiction or treatment in a clinic or hospital for any addiction	○	○
31. Wear a hearing aid or experience frequent tinnitus (ringing in the ears)	○	○
32. Eye surgery, eye injury or blindness in either eye Type of surgery:_____ Date of surgery:_____	○	○
33. Need to wear glasses or contact lens	○	○
34. Mental illness or nervous breakdown	○	○
35. Are you now taking or have you taken any medication in the last 12 months? If yes, what? Medication: _____	○	○
36. Have you ever been hospitalized? If yes, list reason and date of hospitalization. Reason:_____ Date hospitalized: _____	○	○
37. Currently under a doctor's care or any other illness or physical condition not named above	○	○

(Continued on Reverse)

PEACE OFFCIER HEALTH QUESTIONNAIRE

OPOS 13B-PEM (06/08) –Continued

PART D

Please write your own account and evaluation of all items to which you answered "YES" to the questions on Side One. Include **diagnosis, date of onset, your present condidtion as you evaluate it** and what limitations, if any, you feel you may have which would hinder satisfactory performance of the essential functions of the positions for which you are applying (see the enclosed "**ESSENTIAL FUNCTIONS / PHYSICALLY DEMANDING TASKS**"). **Attach additional pages, if necessary.**

PART E

CERTIFICATION: *I certify that I have provided true and complete information concerning my health (Any misrepresentation or material omission may be cause for disqualification or dismissal.)*

CONSENT: *I understand that a comprehensive medical examination is required by California law before appointment as a peace officer. I am voluntarily consenting to undergo a physical examination, which includes taking blood samples, x-rays, and other medical procedures.*

Signature: _____ Date: _____

PRIVACY NOTICE

Agency Responsible for Maintenance: California Department of Corrections and Rehabilitation, Office of Peace Officer Selection, 2201 Broadway, Sacramento, CA 95818-2572

Authority and Purpose: Government Code Sections 188934 and 1031. The information you furnish will be used to determine if you have any medical or emotional condition which would limit your ability to perform the essential functions of the position.

Providing Information: Accepting employment as a peace officer is voluntary. If you choose to accept employment, Government Code Section 1031 requires a medical evaluation before appointment.

Access: Your medical records become confidential information and the property of the Department of Corrections and Rehabilitation. Only authorized personnel directly involved in the selection process will be allowed access.

Social Security Number: Providing your Social Security Number is voluntary in accordance with the Privacy Act of 1974 (PL93-579). However, if your Social Security Number is not included, the Department of Corrections will be unable to process your medical examination.