

HEALTH QUESTIONNAIRE**(With Physician's Report)**

STD. 610 (REV. 12/2002) (Page 1 of 4)

STATE LAW AND THE AMERICANS
WITH DISABILITIES ACT REQUIRE APPLICANTS
TO FILL IN QUESTIONS ON PAGES 1 AND 2 OF THIS FORM
ONLY AFTER A JOB OFFER HAS BEEN MADE

DATE JOB OFFER MADE

SOCIAL SECURITY NUMBER (Optional - See Privacy Statement below.)

THIS AREA TO BE COMPLETED BY HIRING AGENCY – COMPLETED QUESTIONNAIRE WILL BE RETURNED TO HIRING AGENCY

APPLICANT NAME (Last)	(First)	(Middle)	HIRING AGENCY NAME
APPLICANT ADDRESS (Number and Street)	(City)	(State)	(ZIP Code)
CLASS TITLE AND POSITION NUMBER OF VACANCY			HIRING MANAGER'S NAME AND TELEPHONE NUMBER
APPOINTMENT TYPE		DESIRED APPOINTMENT DATE	CERTIFICATION NUMBER
<input type="checkbox"/> PERMANENT <input type="checkbox"/> TAU <input type="checkbox"/> LIMITED TERM <small>(If reinstatement, enter dates of previous State employment.)</small>		CURRENT OCCUPATION	
<input type="checkbox"/> REINSTATEMENT			

THIS AREA TO BE COMPLETED BY THE APPLICANT

DO NOT LEAVE YOUR PRESENT EMPLOYMENT TO ACCEPT A POSITION IN STATE SERVICE UNTIL YOU HAVE BEEN SPECIFICALLY NOTIFIED TO REPORT FOR WORK. MEDICAL CLEARANCE IS REQUIRED PRIOR TO EMPLOYMENT IN STATE SERVICE.

Your answers to the following questions will be evaluated in conjunction with the essential functions of the desired position. In addition, a physical examination may be required. "YES" answers to questions 1 - 43 below must be explained in the space provided on the back of this form.

BIRTH DATE	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	HEIGHT	WEIGHT	
For questions 1–31, have you ever had or do you have the following:					
ITEM	YES	NO	ITEM	YES	NO
1. Lung or respiratory trouble, including bronchitis, tuberculosis, or asthma			27. Gall bladder trouble		
2. Residuals of poliomyelitis			28. Kidney or bladder trouble		
3. Hepatitis, jaundice, or other liver ailments			29. Shortness of breath		
4. Cancer, malignant tumor, or cysts			30. Any speech impairment		
5. Diabetes or sugar in urine			31. History of addiction to drugs or alcohol		
6. Pernicious anemia, leukemia, or other blood disorder or ailment			32. Do you wear or have you ever worn glasses?		
7. Mental illness			33. Do you or have you ever worn contact lenses?		
8. Any disorder of the nervous system			34. Have you had any eye injury, surgery, or disease?		
9. Seizure disorder or loss of consciousness			35. Are you blind in one eye?		
10. Severe headaches or migraine			36. Are you blind in both eyes?		
11. Heart trouble--including circulatory disease			37. Do you wear a hearing aid or have you had at any time a problem with your hearing?		
12. Rheumatic fever			38. Do you have any existing temporary medical condition such as broken bones, recovery from surgery, pregnancy, etc.? If yes, list condition and anticipated date of recovery on Page 2.		
13. Any defect of bones or joints, including amputations, dislocations, or broken bones			39. Are you at present under a doctor's care for any condition? Give reason and doctor's full name and address.		
14. Rheumatism, arthritis, or bursitis			40. Are you taking any medication now or in the last 12 months? If yes, what?		
15. Back pain or back injury			41. Have you ever been hospitalized? If yes, list reason and date of hospitalization.		
16. Head injury			42. a. Have you had an illness or injury which caused you to lose time from work?		
17. Any problems with hips, knees, ankles, or feet			b. Does this illness or injury continue to limit your ability to perform certain types of work?		
18. Any problems with hands, elbows, or shoulders			43. Have you ever had any other illness, injury or physical condition not named above (exclude minor problems such as colds, flu, etc.)?		
19. Fainting spells or dizziness					
20. Skin rash from work					
21. Allergies					
22. Sensitivity to dust or smoke					
23. High or low blood pressure					
24. Varicose veins					
25. Stomach or duodenal ulcer or other bowel problem					
26. Rupture or hernia					

PRIVACY NOTICE


(Continue on reverse.)

Official Responsible: Medical Officer, State Personnel Board, P. O. Box 944201, Sacramento, CA 94244-2010; **Authority:** Government Code Section 18931; **Purpose:** The information you furnish will be used to evaluate your medical fitness to carry out the duties of the position applied for without endangering the health and safety of yourself or others; **Providing Information:** Medical clearance is required prior to employment in State service; **Effects of Not Providing Information:** Omission or misrepresentation may result in placement in a position where the duties or work environment could be hazardous. A misrepresentation or omission may be cause for adverse employment action; **Access:** Your medical records will be maintained in a confidential manner and may be reviewed by contacting the employing agency's personnel office.

HEALTH QUESTIONNAIRE**(With Physician's Report)**

STD. 610 (REV. 12/2002) (Page 2 of 4)

Please write your own account and your own evaluation of all items to which you have answered "YES" to the prior questions. Include DATE OF ONSET, YOUR PRESENT CONDITION AS YOU EVALUATE IT and what accommodations to your limitations, if any, you feel you may require to perform satisfactorily the duties of the position for which you are applying without endangering the health and safety of yourself or others. **Return this completed form to the hiring agency unless (1) advised otherwise by the hiring agency, or (2) if you prefer, send it directly to the Medical Officer, State Personnel Board, P. O. Box 944201, Sacramento, CA 94244-2010. If you choose the latter, be sure to notify the hiring agency you have done so.**


NAMES OF DOCTORS WHO WERE CONSULTED FOR TREATMENT OF CONDITION DESCRIBED ABOVE	DOCTORS' ADDRESSES		
CERTIFICATION: I certify that I have provided true and complete information concerning my fitness. (Any misrepresentation or material omission may be cause for dismissal.)	APPLICANT'S SIGNATURE 	DATE SIGNED	TELEPHONE NUMBER

APPLICANT--DO NOT WRITE BELOW THIS LINE--DELEGATED AUTHORITY OR STATE PERSONNEL BOARD MEDICAL OFFICER ONLY

REVIEWER

 APPROVED **Subject to Proper Placement (STPP)** **DISAPPROVED**

IF DISAPPROVED, STATE JOB-RELATED RATIONALE; IF STPP, STATE RESTRICTIONS

REVIEWING AUTHORITY'S SIGNATURE 	DATE SIGNED	TELEPHONE NUMBER
REVIEWING AUTHORITY'S NAME (Typed or printed)		