New York City Department of Education - Division of Human Capital
HR Connect
65 Court Street, Brooklyn, New York 11201

CONDITIONAL OFFER OF EMPLOYMENT MEDICAL FORM

SECTION I - Parts A and B must be completed and SIGNED by the applicant

A. PERSONAL INFORMATION

FIRST NAME | M.I. | LAST NAME

HOME ADDRESS | APT #

CITY | STATE | ZIP CODE

HOME TELEPHONE — — GENDER: ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER — — DATE OF BIRTH: _____

GENERAL INSTRUCTIONS

Applicants are required to provide medical documentation to determine fitness prior to employment with the Department of Education. You are not required to submit this form until after you have been offered a position. However, you may want to have this form completed by your physician in advance. The applicant must fill out Section I, Parts A and B, and your personal physician must fill out Section II. All physical examinations must have been performed WITHIN 6 MONTHS of the offer of employment. We recommend that you review your form prior to submission to ensure that it is completed by both you and your physician. Please make sure that you have signed your medical form. Your completed form must be submitted to the Operations Center for your region/district.

Please submit this form through the Upload Document feature of the **HR Connect Portal** at https://doehrconnect.custhelp.com. If you are a DOE employee, you will need to log in with your DOE username and password. Non-employees must create an account

Keep a copy for your files. Be advised that your responsibility center may ask the Medical Bureau to review your form. This may necessitate your being called in for an examination or the submission of additional medical documentation in order to determine your fitness for duty.

B. MEDICAL HISTORY: (To be filled out by applicant.)

ALLERGIES: _____

SOCIAL HISTORY: (cigarette smoking, alcohol usage, drug usage)

CURRENT MEDICATIONS: (dosage, duration and reason for usage)

LIST ANY SERIOUS ILLNESS OR TRAUMATIC INJURY, HOSPITALIZATION, SURGERY, ETC.

HAVE YOU ANY REPIRATORY CONDITIONS OR SYMPTOMS? (asthma, shortness of breath, wheezing, chronic cough, etc.)

HAVE YOU ANY CARDIOVASCULAR SYMPTOMS? (high blood pressure, chest pain, murmurs, palpitations, dizziness, etc.)

HAVE YOU ANY JOINT/MUSCLE PAINS OR SWELLING; NECK/BACK PROBLEMS?

HAVE YOU EXPERIENCED HEADACHES, FATIGUE, DIZZINESS, FAINTING OR SEIZURES?

HAVE YOU ANY MENTAL OR EMOTIONAL DISORDERS THAT YOU WISH TO INFORM US ABOUT, EITHER CURRENTLY OR IN THE PAST

_____ _____

Applicant's Signature **Date**

SECTION II: PHYSICAL EXAMINATION (To be completed by applicant's physician)

NAME: _____ Social Security Number: ☐☐☐ ☐☐ ☐☐☐☐

General Description: (including nutritional status, personal hygiene and noticeable aspects of personal appearance)

VITAL SIGNS: Pulse _____ Resp. _____ Temp. _____ BP _____ Weight _____ Height _____

VISION ACUITY: **Without Glasses:** right ____/____ left ___/____ **With Glasses:** right ____/____ left ___/____

IMMUNIZATIONS (state approximate dates): Tetanus _____ Hepatitis B _____ Rubella _____ Mumps _____

Check if Within Normal Limits (WNL). If not, please comment.

- ☐ **EYES:** _____
- ☐ **EARS:** _____
- ☐ **NOSE/THROAT:** _____
- ☐ **NECK:** _____
- ☐ **LUNGS:** _____
- ☐ **HEART:** _____
- ☐ **ABDOMEN:** _____
- ☐ **SPINE:** _____
- ☐ **EXTREMITIES/JOINTS:** _____
- ☐ **NEUROLOGIC:** _____

IS APPLICANT **FREE** OF COMMUNICABLE DISEASE? ☐ **YES** ☐ **NO**

ONGOING MEDICAL PROBLEMS:

MEDICAL RESTRICTIONS: (Explain)

IS APPLICANT MEDICALLY QUALIFIED TO WORK IN HIS?HER JOB TITLE? ☐ **YES** ☐ **NO**

COMMENTS:

_____ ☐☐☐☐☐☐☐☐

Physician's Signature and Stamp **Date**

Print Name, Address and Telephone No.: _____