

Clatskanie Rural Fire Protection District Annual Medical Statement and Report

Date: _____

Section 1: Personal Information

Name: _____ Home Address: _____

Mailing Address (if different): _____ City, State, Zip: _____

Birthdate: _____ Hire Date: _____

I am Paid Full-Time, Paid Part-Time or Volunteer

Personal Physician: _____ City: _____

Section 2: Recent Medical Care

In the past one year, have you experienced any illness or injury that:

1. Required hospitalization? Yes No
2. Caused a physician to place a physical restriction on you? Yes No
3. Caused a long term or permanent disability? Yes No
4. Requires you to be on continuous medication(s)? Yes No

If you answered yes to any of the above questions, please write a brief explanation below.

Section 3: Medical History

Have you, to the best of your knowledge, suffered any of the following conditions in the past two years or since your last medical report to this department?

1. Diabetes or Hypoglycemia Yes No
2. Seizures, Convulsions or Fainting Spells Yes No
3. Asthma, Emphysema, or other respiratory disorder Yes No
4. Cardiac Symptoms, Chest Pain, Angina, or Irregular Heartbeat Yes No
5. High Blood Pressure Yes No
6. Liver or Kidney Ailment Yes No
7. Infectious Disease other than cold or flu Yes No
8. Spinal or Back Injury Yes No
9. Psychiatric Disorders or Depression Yes No
10. Drug and/or Alcohol Dependency Yes No
11. Hear or Vision Disorders Yes No

Section 4: Health Statement

Please list any significant medical conditions not already covered.

List all medications you are currently prescribed.

List any allergies you may have, especially to medications

I have read this form and answered it honestly and correctly to the best of my knowledge. I understand that it is in my best interest to make any and all medical information available to the Fire District and that all such information is personal and confidential.

Signature: _____

Date: _____

Compliance Statement

I, _____, have been issued a copy of the Clatskanie Rural Fire Protection District's Operations Manual. I have read this manual and agree to comply with the manual whenever I am acting as a member of this department.

I further state that I am not addicted to alcohol or other controlled substances, and that I am free from any physical or mental defect that might impair my ability to operate safely in the fire service.

Employee Signature: _____ Date: _____

Clatskanie Rural Fire Protection District
EMPLOYEE CONFIDENTIALITY AGREEMENT

Given the nature of our work, it is imperative that we maintain the confidence of patient information that we receive in the course of our work. Clatskanie Rural Fire Protection District prohibits the release of any patient information to anyone outside the organization unless required for purposes of treatment, payment, or health care operations and discussion of "Protected Health Information" within the organization should be limited.

Acceptable uses of protected health information within the organization include, but are not limited to, exchange of patient information needed for the treatment of the patient, billing, and other essential health care operations, peer review, internal audits, and quality assurance activities.

I understand that Clatskanie Rural Fire Protection District provides services to patients that are private and confidential and that I am a crucial step in respecting the privacy rights of the Clatskanie Rural Fire Protection District's patients. I understand that it is necessary, in the rendering of Clatskanie Rural Fire Protection District services, that patients provide personal information and that such information may exist in a variety of forms such as electronic, oral, written or photographic and that all such information is strictly confidential and protected by federal and state laws.

I agree that I will comply with all confidentiality policies and procedures set in place by Clatskanie Rural Fire Protection District during my entire employment or inadvertently breach the patient confidentiality policies and procedures, I agree to notify the Privacy Officer of Clatskanie Rural Fire Protection District immediately. In addition, I understand that a breach of patient confidentiality may result in suspension or termination of my employment or association with Clatskanie Rural Fire Protection District. Upon termination of my employment or association for any reason, or at any time upon request, I agree to return any and all patient confidential information in my possession. This is not a contract for continued employment.

I have read and understand all privacy policies and procedures that have been provided to me by Clatskanie Rural Fire Protection District. I agree to abide by all policies or be subject to disciplinary action, which may include verbal or written warning, suspension, or termination of employment or of any membership or association with Clatskanie Rural Fire Protection District. This is not a contract of employment and does not alter the nature of the existing relationship between Clatskanie Rural Fire Protection District and me.

Signature: _____ Date: _____

Printed Name: _____