Mechanicsville Volunteer Rescue Squad, Inc.

28120 Old Flora Corner Road
P.O. BOX 15
MECHANICSVILLE, MARYLAND 20659

Dear Attending Physician,

_____has/ or is
Applicant's/ Member's Name

_____ Applied for Membership with the Mechanicsville Volunteer Rescue Squad

_____ Applied for Administrative Membership Only*

_____ A Member of The Mechanicsville Volunteer Rescue Squad that has been on Medical Leave

To assume full, active duty in the organization the applicant/member must be capable of performing multiple physical and mental tasks in Emergency Medical Services response. These tasks/duties could include, but are not limited to:

Exposure to stressful situations
Lifting heavy objects, equipment and patients
Climbing on and off tall vehicles
Driving emergency vehicles
Radio communications*
Non-riding member*

Please review the attached form that has been completed by the applicant/member and feel free to add any comments. If you have any questions or concerns, please do not hesitate to contact our Chief at 301-884-2900.

Sincerely,

The Mechanicsville Volunteer Rescue Squad

www.co29.org
Phone: 301-884-2900 Fax: 301-884-2930

HEALTH HISTORY FORM

(To be completed by Applicant/Member and reviewed by Physician)

Please answer the following questions with a Yes or No… **if yes please give details/dates.**

Have you ever had or do you currently have:	Yes	No	If "YES," Give Details
EYES/EARS:			
Hearing Loss	__	__	_____
Do you wear a Hearing Aid?	__	__	_____
Does Hearing Aid interfere with radio communications?	__	__	_____
Do you wear Glasses/Contacts?	__	__	_____
Declared legally blind	__	__	_____
LUNGS:			
Asthma or Wheezing	__	__	_____
TB or a Positive Skin Test	__	__	_____
Short of Breath on Exertion	__	__	_____
Chronic Cough	__	__	_____
HEART:			
Heart Disease/Heart Condition	__	__	_____
High Blood Pressure	__	__	_____
Stroke	__	__	_____
Chest Pain with activity	__	__	_____
Chest Discomfort with activity	__	__	_____
Heart Surgery or Angioplasty	__	__	_____
NEURO:			
Numbness/Weakness/Paralysis	__	__	_____
Dizziness or Fainting Spells	__	__	_____
Seizures or Blackouts	__	__	_____
Head Injury or Concussion	__	__	_____
GENERAL:			
Diabetes	__	__	_____
Given Light Duty	__	__	_____
Weight Restriction for Lifting	__	__	_____
Any Other Injuries or Illnesses	__	__	_____
Tetanus Booster	__	__	Date: _____
Hepatitis B Immunization	__	__	Dates: _____1st _____2nd _____3rd
T. B. Skin Test	__	__	Date: _____Reading:_____
EKG (over the age of 40)	__	__	_____
Chest X-Ray	__	__	_____
Recent Surgery	__	__	Date: _____ Type: _____

Health Care Treatment:

Medical	__	__	_____
Surgery	__	__	_____
Psychiatric	__	__	_____
Physical Therapy	__	__	_____
Allergies	__	__	_____
List of Medications	__	__	_____

Current Vital Signs:
Blood Pressure: _____/_____ Pulse Rate: _____

Height: _____ Weight: _____

Any additional comments: _____

_____

_____

_____

Note: ACTIVE DUTY is without any restrictions, limitations or special considerations to perform all tasks.

I (physician) certify, by my signature below that the applicant/member is physically and mentally qualified for **ACTIVE DUTY / LIGHT DUTY** in this organization.
(**Physician** circle appropriate duty)

_____ _____
Date **Physician's Name** **Printed**

_____ _____
Doctor's Office Stamp **Physician's Signature**

_____ _____
Date **Applicant/Member Name** **Printed**

_____
Signature of
Applicant, Parent/Guardian or Member