

REPORT OF STATE CONSTABLE EXAMINATION

TO THE EXAMINING PHYSICIAN:

All information **MUST** be completed. Please type or print legibly and return to the Constable candidate and/or the South Carolina State Law Enforcement Division (SLED).

PHYSICIAN'S NAME: _____

ADDRESS: _____

PHONE: _____

PATIENT/CANDIDATE'S NAME: _____

Social Security No.: _____

THE ABOVE NAMED CANDIDATE IS:

Medically **Suitable** for the SC State Constables Program

Medically **Unsuitable** for the SC State Constables Program for the following reasons:

COMMENTS: _____

The medical history and physical examination results for this Candidate are on file in the Physician's office at the above address and will be made available to the SC State Law Enforcement Division upon request. The Candidate has been informed of the examination results and the presence of any conditions which may need follow-up evaluation. If questions of suitability should arise during the course of training, a candidate may be required to obtain follow-up medical evaluation at the expense of the candidate.

Date: _____ Physician's signature: _____

Date: _____ Candidate's signature: _____

NOTE: ALL information must be completed above, the Physician must check medically suitable/unsuitable and sign and date this page. The Candidate must sign and date this page as well.

STATE CONSTABLE CONSENT AND MEDICAL HISTORY

Name _____ Age _____ SSN _____

Home Address _____ Phone _____

_____ Date of Birth _____

The answers that I give are true to the best of my knowledge. This information will be used to determine whether I am medically capable of performing the essential functions of the physical demands while assisting law enforcement with the State Constable Program. Medical information regarding my ability to perform these activities will be made available to SLED. Other Information will be held strictly confidential.

Signature _____ Date _____

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|--|--------------------|--|--|-----|----|----------|--|--|---------------------|--|--|---------------|--|--|--------|--|--|--------|--|--|-------------------|--|--|
| <p>1. Do you have or have you ever had:</p> <p>Measles</p> <p>Bronchitis</p> <p>Mumps</p> <p>Chickenpox</p> <p>Seizures</p> <p>Pneumonia</p> <p>Tuberculosis (TB)</p> <p>Cancer</p> <p>Diabetes</p> <p>Blood Problems</p> <p>High Blood Pressure</p> <p>Heart Problems</p> <p>Kidney Problems</p> <p>Ulcers</p> <p>Arthritis</p> <p>Hernia</p> <p>Hemorrhoids</p> <p>Skin Problems</p> <p>Back Problems</p> <p>Asthma</p> <p>Lung Problems</p> <p>Mental Illness</p> <p>Hepatitis</p> <p>Surgery</p> <p>Significant Injuries</p> | <p>YES NO</p> | <p>2. Are you allergic to any medicines, food or other substances? _____</p> <p>3. Do you use:</p> <p style="padding-left: 40px;">Yes/ No/ How Much/ In Past?</p> <p>Cigarettes _____</p> <p>Alcohol _____</p> <p>Drugs _____</p> <p>4. List all medications you take regularly:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>5. Family History: Have your mother, father, sister or brother had the following:</p> <table border="0" style="margin-left: 40px;"> <tr> <td></td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td>Diabetes</td> <td></td> <td></td> </tr> <tr> <td>High Blood Pressure</td> <td></td> <td></td> </tr> <tr> <td>Heart Disease</td> <td></td> <td></td> </tr> <tr> <td>Cancer</td> <td></td> <td></td> </tr> <tr> <td>Stroke</td> <td></td> <td></td> </tr> <tr> <td>Tuberculosis (TB)</td> <td></td> <td></td> </tr> </table> <p>Explain _____</p> <p>Explain _____</p> | | Yes | No | Diabetes | | | High Blood Pressure | | | Heart Disease | | | Cancer | | | Stroke | | | Tuberculosis (TB) | | |
| | Yes | No | | | | | | | | | | | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | | | | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | | | | | | | | | | | | | | |
| Heart Disease | | | | | | | | | | | | | | | | | | | | | | | |
| Cancer | | | | | | | | | | | | | | | | | | | | | | | |
| Stroke | | | | | | | | | | | | | | | | | | | | | | | |
| Tuberculosis (TB) | | | | | | | | | | | | | | | | | | | | | | | |

Current Occupation _____ Job you have held longest _____

Have you ever been exposed to fumes, dust, chemicals, loud noise or radiation at work or elsewhere?
yes no Explain _____

Have you ever been unable to hold a job because of medical reasons? yes no
Explain _____

Have you ever received Workers' Compensation? yes no
Explain _____

Have you lost time from work for medical reasons in the past five years? yes no
Explain _____

Examiner's Comments _____

STATE CONSTABLE EXAMINATION

Height _____

Weight _____

Blood Pressure _____

Pulse _____

Visual Acuity (R) _____ (L) _____ Without Correction

(R) _____ (L) _____ With Correction

Color Vision _____

	Normal	Abnormal	Explanation
Eyes			
Ears			
Hearing			
Nose			
Throat			
Mouth			
Neck			
Abdomen			
Hernia			
Genitourinary			
Back			
Extremities			
Upper			
Lower			
Neurologic			
Skin			
U.A.	pH _____	s.g. _____	Chemistry _____
TB Skin Test	_____		

Medically **Suitable** for the SC State Constables Program

Medically **Unsuitable** for the SC State Constables Program for the following reasons: _____

COMMENTS: _____

Date: _____

Physician's Signature _____