



MEMBER'S MEDICAL QUESTIONNAIRE and examining physician's certification

Sections A, B and C of this form are to be completed by the prospective member of the Ohio Police & Fire Pension Fund (OP&F). Sections D and E are to be completed by the licensed examining physician, including the date.

Section A: Patient information

Name: First, MI, Last, suffix (Jr. III, etc.)		Social Security Number					
Street Address / Post office box		<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>					
City, State, ZIP code		Date of Birth					
Home phone: _____		<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>					
Alternate phone: _____		Potential Date of Hire					
Name of potential employer: _____		<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>					
		Check one: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	Check one: <input type="checkbox"/> POLICE <input type="checkbox"/> FIRE				

Section B: Medical History

If yes to any of the questions below, please explain in the space provided:
 (use back of this form if necessary)

	Medication ▼	Dosage ▼	Frequency ▼
Do you take any prescription or over the counter medications? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you had any other injuries or serious illnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you been under a doctor's care in the past two years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has your work ever been limited or restricted due to your health? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you had any physical complaint, impairment or disability? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you had any condition requiring a special work assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever had or been advised to have an operation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much?	How many years?	
Do you use alcohol or intoxicating liquor? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much?	How often?	
How many days off have you had in the past two years due to illness or injury?			
What is your current state of health? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			

Check conditions you currently have or have had:

<input type="checkbox"/> Arthritis, swollen/painful joints	<input type="checkbox"/> Ear, nose, throat trouble	<input type="checkbox"/> Liver disease or jaundice	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Asthma, bronchitis	<input type="checkbox"/> Emphysema, shortness of breath	<input type="checkbox"/> Measles	<input type="checkbox"/> Tuberculosis, silicosis
<input type="checkbox"/> Back trouble of any kind	<input type="checkbox"/> Epilepsy, seizures	<input type="checkbox"/> Menstrual disorders	<input type="checkbox"/> Varicose veins, phlebitis
<input type="checkbox"/> Blood transfusions, hemophilia	<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Mental illness, depression, anxiety, nervousness	<input type="checkbox"/> Vision difficulties, eye injury/defect
<input type="checkbox"/> Bone, joint deformity	<input type="checkbox"/> Foot problems	<input type="checkbox"/> Neurological (nerve) problem	<input type="checkbox"/> Allergies (drug, food, insect, etc.) Please list allergy and reaction:
<input type="checkbox"/> Bowel habit change	<input type="checkbox"/> Glaucoma or cataracts	<input type="checkbox"/> Numbness, weakness, fatigue	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> Chest pain/pressure	<input type="checkbox"/> Hearing difficulties	<input type="checkbox"/> Rash, hives	_____
<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Rheumatic fever	_____
<input type="checkbox"/> Coughing/vomiting blood	<input type="checkbox"/> Hemorrhoids (piles)	<input type="checkbox"/> Scarlet Fever	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sexually Transmitted Disease (STD)	_____
<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Hernia	<input type="checkbox"/> Shin/Knee trouble	_____
<input type="checkbox"/> Dizziness	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Stomach trouble, ulcers	_____
<input type="checkbox"/> Drug problems, IV drug use	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Swelling of the ankles or feet	_____

Section B: Medical History (continued)

Date of last tetanus shot:

Not sure

Family Medical History

Please indicate the status of the following blood relatives:

Mother: Living? Yes (age: _____), No (age and cause of death): _____

Father: Living? Yes (age: _____), No (age and cause of death): _____

Maternal grandmother: Living? Yes (age: _____), No (age and cause of death): _____

Maternal grandfather: Living? Yes (age: _____), No (age and cause of death): _____

Paternal grandmother: Living? Yes (age: _____), No (age and cause of death): _____

Paternal grandfather: Living? Yes (age: _____), No (age and cause of death): _____

Siblings: Living? Yes (age: _____), No (age and cause of death): _____

Living? Yes (age: _____), No (age and cause of death): _____

Living? Yes (age: _____), No (age and cause of death): _____

Indicate if any of the below illnesses have occurred in your blood relatives listed above:

<input type="checkbox"/> Alzheimer's disease: If so, who?	<input type="checkbox"/> High blood pressure: If so, who?
<input type="checkbox"/> Arthritis: If so, who?	<input type="checkbox"/> High cholesterol: If so, who?
<input type="checkbox"/> Asthma: If so, who?	<input type="checkbox"/> Lung disease: If so, who?
<input type="checkbox"/> Breast cancer: If so, who?	<input type="checkbox"/> Mental illness: If so, who?
<input type="checkbox"/> Colon cancer: If so, who?	<input type="checkbox"/> Stroke: If so, who?
<input type="checkbox"/> Diabetes: If so, who?	<input type="checkbox"/> Thyroid disease: If so, who?
<input type="checkbox"/> Heart disease: If so, who?	<input type="checkbox"/> Tuberculosis (TB): If so, who?

Section C: Authorization to release medical records and acknowledgement

An authorization to release the medical records is needed in order to allow the examining physician to forward such medical tests and reports to OP&F. By failing to grant the authorization provided in this section, you acknowledge and agree that to the extent you become a member of OP&F, you will not be permitted to use the presumption conditions of disability provided under Ohio law.

I, the person described in section A of this form, represent that I am the person herein described; I agree that all statements made are true and correct and also authorize the examining licensed physician who examined me to release to OP&F the physician's report and certification, as referenced herein.

Signature of prospective member:

Date of signature:



Examining licensed physician's certification

(as required by Ohio Revised Code 742.38 and Ohio Administrative Code 742-1-02)

Section D: Tests and procedures to be administered and submitted

A prospective member of OP&F must undergo the tests and procedures set forth in this section. The examining physician, who must be licensed to practice medicine in the state in which the examination was conducted, must sign the certification provided in Section E below, or a form substantially similar, as determined by OP&F in its sole and absolute discretion. The certification must include the physician's diagnosis and evaluation of the existence of any heart disease, cardiovascular disease or respiratory disease identified in the questionnaire, medical tests and physical examination referred to below. Copies of these tests and procedures must be included as part of the physician's report. **ALL INFORMATION MUST BE FILLED OUT COMPLETELY.**

It is the employer's responsibility to timely file the following:

- Electrocardiogram (EKG) and cardiac stress test performed consistent with standard Bruce protocol;
- Chest x-ray that is at least a P.A. 72" (i.e. front to back);
- Lipid profile that includes total cholesterol, triglycerides, LDL and HDL levels;
- Spirometry that represents at least a valid and reproducible forced expiratory volume at one (1) second (FEV1), forced vital capacity (FVC), and forced expiratory volume at one second/forced vital capacity (FEV1/FVC) that meets the criteria of the American Thoracic Society;
- Examining physician's certification (Section E of this form)
- Completed Member's Medical Questionnaire (Sections A, B and C of this form)

Section E: Examining Physician's Certification

Opinion of the Examining Licensed Physician:

The undersigned physician hereby certifies that: _____
(person being examined)

has undergone the tests and procedures referred to in Section D above on: _____
(date of exam)

Based on these tests and the physical exam:

Select **one** and *initial*:

1: _____ **There is no evidence** of the existence of any heart disease, cardiovascular disease or respiratory disease.
(initial)

2: _____ **There is evidence** of either heart disease, cardiovascular disease or respiratory disease (explain below).
(initial)

Diagnosis/conclusions: _____

Physician's name:	Phone number
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Physician's street address / Post office box

City, State, Zip Code

Physician's signature: 	Date of signature:
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(the signature of a nurse practitioner or physician's assistant is **not** valid on this certification)



Ohio Police & Fire Pension Fund
140 East Town Street
Columbus, OH 43215
Phone: 888-864-8363
Fax: (614) 628-1777
www.op-f.org