* must call or email to make appointment *

ALBANY MED
EmUrgentCare®

Alyssa Rogers-518-264-1922-rogersa1@amc.edu
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Occupational Medicine Services

Referral Form

Village of Coxsackie gives permission to have
(Employer)

_____
(Employee Name)
Seen at Albany Medical Center EmUrgentCare FOR THE PURPOSE OF:

☐ **Physical Exam** Circle which: Basic / DOT
- Review of medical history
- Vital signs
- Physical Exam
- Vision Test/Hearing/Urinalysis

☐ **Physical Exam with Agility** OHAGILIT
- Review of medical history
- Vital signs
- Physical Exam
- Vision/Hearing/Urinalysis
- Agility (lifting of 40lbs and 80lbs)

☐ **Annual Respirator Clearance Exam** OHRESPIR
- Review of medical history
- Vital signs
- Physical Exam
- Review of OSHA questionnaire
- Respirator clearance
- Qualitative fit test
- Pulmonary function test
- EKG (over 40 or if medically necessary for additional charge of $50)

☐ **Drug Screen**
Circle one: DOT NON-DOT
Circle Type: Pre-Employment/Random/For Cause Post Accident/Reasonable Suspicion

Check Test Required:

☐ Urine Collection w/ Dr. Hassett MRO

☐ Urine Collection fax results to MRO

☐ Instant Toxicology

☐ Breathalyzer for Alcohol (EBT) OHETOH

☐ Audio Testing OHAUDIO

☐ Ishihara Vision Testing OHVISION

☐ Pulmonary Function Test OHPULMON

☐ Chest X-ray OHCHESTX

☐ Qualitative Fit Testing (bring mask) OHQUANT

☐ Review of OSHA Questionnaire OHOSHA

☐ Hepatitis B Vaccine OHHEPB

☐ Tetanus Vaccine OHTETAN

☐ TB/PPD Skin Test OHPPD

☒ OTHER Firefighter physical

COMPANY AUTHORIZATION

Nikki Berezniak
Authorized Name (print)

Authorized Signature

/ /
Date

(518) 731-2718
Telephone

Please call for an appointment for all physicals with drug screens. Photo ID required for all visits

Brunswick – 730 Hoosick Rd. Brunswick, NY 12180	Mechanicville – 7 Price Chopper Plaza Mechanicville, NY 12118
Coxsackie – 11835 Rt 9W West Coxsackie, NY 12192	Niskayuna – 1769 Union St. Niskayuna, NY 12309
Glenmont – 329 Glenmont Rd. Glenmont, NY 12077	Rotterdam – 1400 Altamont Ave. Rotterdam, NY 12303
Glenville – 115 Saratoga Rd, Glenville, NY 12302	Saugerties – 2976 Rt 9W Saugerties, NY 12477
Guilderland – 5 New Karner Rd. Guilderland, NY 12084	Wolf Rd – 98 Wolf Rd. Albany, NY 12205
Latham – 1019 New Loudon Rd. Latham, NY 12047	

ALBANY MED
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(518) 264-9000 Fax: 518-731-9119

Firefighter Evaluation Form

PLEASE COMPLETE THE FOLLOWING INFORMATION

Fire Company: _____

Name: _____

DOB: _____

Primary Care Physician: _____

PCP Phone Number and Practice name: _____

Firefighter Categories:
Category A: Interior firefighter: Must be able to utilize a respirator, carry victim and preform strenuous activity with no limitations – physical, urine dip, PFT, EKG

Category B: Exterior Firefighting: Must be able to perform strenuous physical exertion and have no limitations. Emergency use of respirator for no more than 30min – physical, urine dip, PFT, EKG

Category C: Exterior Support: Must be able to fight brush fires, vehicle extrication, assist at structure fires, rope r water rescue and drive trucks. No use of respirator. – physical, urine dip, EKG

Category D: Administrative/Fire police: Must be able to stand for long periods of time directing traffic. Must be able to move out of the way of oncoming traffic if needed. – physical, urine dip, EKG

Which category are you currently? A B C D

Which category are you requesting? A B C D

Office use only

___ Firefighter Physical Exam

___ Urine Dip Pass Fail

___ Fingerstick Glucose Pass Fail

___ Fit test Pass Fail

___ PFT Pass Fail

___ EKG Pass Fail

___ Audiogram Pass Fail

___ OSHA Form Reviewed

Comments:
_____
_____
_____

Approved for Category: A B C D None

Provider Name:_____ Date: _____

Signature: _____

Audiogram only if whisper test fails
Fingerstick only if glycosuria
If fit test is requested OSHA form is needed as well (category A and B)

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PHYSICAL EXAMINATION
TO BE COMPLETED BY NEW HIRE

A copy of this document should be forwarded to Employer HR Department

Name:	
SSN:	
(Company Name):	

MEDICAL HEALTH HISTORY: TO BE COMPLETED PRIOR TO PHYICAL EXAM					
CONDITION	YES	NO	CONDITION	YES	NO
Head/brain injuries or illnesses			Unexplained weight loss or gain		
Seizures, epilepsy			Stroke, TIA, paralysis or weakness		
Eye problems (except for glasses)			Missing or limited use of arm, hand, finger, leg, foot or toe		
Heart disease, heart attack, bypass			Neck or back problems		
Pacemaker, stents, or other devices			Bone, muscle, joint or nerve problems		
High blood pressure			Blood clots or bleeding disorders		
High cholesterol			Cancer		
Chronic cough, shortness of breath			Chronic infections or other chronic diseases		
Lung disease (ie asthma, COPD)			Sleep disorders, pauses in breathing while sleeping, daytime sleepiness, loud snoring		
Kidney problems or pain with urination			Hospitalizations		
Stomach, liver or digestive problems			Operations		
Diabetes			Do you currently use or have you used tobacco?		
Anxiety, depression, or other mental health disorders			Current alcohol use		
Fainting or passing out			Drug abuse		
Dizziness, headaches, numbness, tingling or memory loss					
Did you answer yes to any questions please comment further:					
Current Medications:					

FOR OFFICE USE ONLY

☐ PHYSICAL EXAM	☐ PPD
☐ AGILITY	☐ URINE DRUG SCREEN
☐ PFT'S	☐ BAT
☐ FIT TESTING	☐ ECG
☐ CXR	☐ AUDIOGRAM
Conclusions: Based on my review of questionnaire and physical exam, this individual:	
☐ Individual is cleared with no restrictions to wear respirator Type of Respirator:	
☐ Individual is cleared with restrictions to wear respirator:	
☐ Individual is not cleared to wear respirator	
Physician's Signature: **Date:**	