5.06 Medical Examinations & Drug Testing Provisions	Review Date: 01/02/2023
	Effective Date: 01/24/2023

Medical Examination and Drug Testing Provisions

Purpose

Putnam County Board of County Commissioners has a compelling interest in maintaining a safe, healthy and productive work environment for all its employees; in providing professional services for its customers in a safe, timely and efficient manner; in maintaining the security of its equipment and workplace; and in performing all these functions in a fashion consistent with the interests and concerns of the community.

In order to ascertain candidates' and employees' abilities to perform essential job functions, the county requires completion of a pre-employment medical questionnaire. Employee information disclosed will remain confidential, unless the law requires disclosure (example: subpoena). Any required medical examinations are conducted in compliance with Title I of the Americans with Disabilities Act of 1990 and other applicable laws. Drug testing is intended to deter drug and alcohol abuse by employees in order to limit illness and injury to themselves and to others. **The County assumes the cost of all such examinations.**

Scope and Prohibitions

1. County employees are strictly prohibited from engaging in any of the following acts while on county premises or within county facilities, while conducting County-related work off County premises, or while operating County vehicles:

    - Unlawful possession, use, consumption, sale, purchase, distribution, dispensation or manufacture of any illegal drug; or

    - Consumption of alcoholic beverages; or

    - Misuse of legally obtained drugs.

2. The County:

    - Will not permit any employee to report to work nor to perform duties with the presence of any illegal drug in his/her system; or with a blood-alcohol level as defined in Florida Statutes 316.1932(1)(b)m of 0.04 percent or more; or if his/her senses are impaired due to misuse of legally obtained drugs.

    - Will not permit any safety-sensitive employee to:

        (a) report to work with an alcohol concentration of 0.02 or greater
        (b) perform safety sensitive functions within four (4) hours of using alcohol
        (c) consume alcohol for eight (8) hours following an accident unless employee has undergone and tested clean after being administered a post-accident alcohol test

(d) perform or continue to perform safety sensitive functions with an alcohol concentration of 0.02 or greater.

- Will not permit employees to consume alcohol during the hours the employee is on call.

- Will require any employee to submit to an alcohol breath test if there is reasonable suspicion of alcohol ingestion during working hours.

- Will not permit any employee to report to work or to perform his/her duties while taking prescription or non-prescription medication which adversely affects the person's ability to safely and effectively perform his or her job functions. Employees are required to notify their supervisors of prescription or over-the-counter medication which carries a warning label that indicates mental functioning, or motor skills, or judgment may be adversely affected. Medical advice will then be sought, as appropriate, before allowing the employee to return to performing work-related duties.

- Will require any employee to report any criminal drug statute conviction, or a finding of guilt whether or not adjudication is withheld, or the entry into a diversionary program in lieu of prosecution to the Human Resources Director no later than five (5) days after such conviction. Any employee who fails to notify the Human Resources Director will be subject to disciplinary action, up to and including termination.

3. Any employee who violates this policy is subject to disciplinary action, up to and/or including discharge.

NEW HIRE MEDICAL QUESTIONNAIRE

All employees

The purpose of this questionnaire is to help determine your ability to perform the essential job duties for the position for which you have been offered. It is also a tool to help assess whether accommodations are appropriate or required, and/or your need for special or emergency medical procedures. Some job classifications may require additional information and examination.

This form will become a permanent document in your employee medical record and will remain CONFIDENTIAL.

Name: _____

A. Do you now have or have you ever had any of the following:

Check Each Item	Yes	No		Yes	No
1. Allergies	☐	☐	27. Hemorrhoids	☐	☐
2. Anemia	☐	☐	28. Chronic Diarrhea	☐	☐
3. Arthritis	☐	☐	29. Heart Disorder	☐	☐
4. Asthma	☐	☐	30. Artery Disease	☐	☐
5. Emphysema	☐	☐	31. Phlebitis	☐	☐
6. Pneumonia	☐	☐	32. Hemophilia	☐	☐
7. Chronic Cough	☐	☐	33. Varicose Veins	☐	☐
8. Frequent Colds	☐	☐	34. Polio	☐	☐
9. Nose Troubles	☐	☐	35. Rheumatic Fever	☐	☐
10. Tuberculosis	☐	☐	36. Multiple Sclerosis	☐	☐
11. Vision Problems	☐	☐	37. High Blood Pressure	☐	☐
12. Hearing Problems	☐	☐	38. Emotional Problems	☐	☐
13. Frequent Headaches	☐	☐	39. Mental Disturbances	☐	☐
14. Convulsions/Seizures	☐	☐	40. Dental Problems	☐	☐
15. Dizziness	☐	☐	41. Head Injury	☐	☐
16. Fainting	☐	☐	42. Neck Injury	☐	☐
17. Epilepsy	☐	☐	43. Shoulder, Arm or Hand Injury	☐	☐
18. Frequent Indigestion	☐	☐	44. Back Injury or Pain	☐	☐
19. Ulcers	☐	☐	45. Hip, Knee, or Leg Injury	☐	☐
20. Cancer	☐	☐	46. Ankle or Foot Injury	☐	☐
21. Diabetes	☐	☐	47. Silicosis	☐	☐
22. Hypoglycemia	☐	☐	48. Skin Disease	☐	☐
23. Difficulty In Urination	☐	☐	49. Thyroid Disease	☐	☐
24. Kidney Trouble	☐	☐	50. Gastrointestinal Disease	☐	☐
25. Hepatitis	☐	☐	51. Infectious Disease	☐	☐
26. Hernia	☐	☐			

B. Answer yes or no to the following questions:

	Yes	No
53. Are you on any medication?	☐	☐
54. Were you ever a hospital patient?	☐	☐
55. Have you ever had an operation?	☐	☐
56. Did you ever receive a physical or mental disability rating?	☐	☐
57. Do you have a physical disability or impairment?	☐	☐
58. Are you currently under a physician's care for any condition?	☐	☐
59. Are you allergic to any medications?	☐	☐

C. Explain all yes answers including the item number, name of the condition, the date of occurrence, and surgeries and dates of surgery.

D. Emergency Contacts: Please list emergency contacts here, as well as your current physician information:

NAME	PHONE NUMBER
Emergency contact	
Emergency contact	
Primary Care Provider	

E. Certification

I certify that I have given the above information and to the best of my knowledge, it is true and complete. I hereby authorize any doctor, hospital or clinic who has rendered treatment to me to release a complete transcript of my record to the bearer of this authorization. In the event of my employment, I understand that any misleading or incorrect statements may be cause for immediate dismissal.

Applicants' Signature

Date

Witness' Signature

Revised: May 2022

PUTNAM COUNTY
BOARD OF COUNTY COMMISSIONERS
PHYSICIAN'S FORM
Fire, Rescue, Emergency Response Candidates

Name: _____ Position: _____

This examination should identify any physical abnormalities, deficiencies or emotional instability that may impair the applicant's ability to perform the full duties of the position listed above (position description attached).

Vital Signs: Temperature_____ Pulse_____ Respiration_____

Height: _____ ft._____ in. Weight: _____lbs.

			Normal	Abnormal
Vision:	Right 20/____	Left 20/_____ Color Perception	☐	☐
Hearing:	Right____/15	Left _____/15	☐	☐
Nose & Sinuses:	Deformity, Obstruction, Chronic infection		☐	☐
Neck:	Thyroid enlargement, Adenopathy		☐	☐
Thorax:	Inadequate expansion, deformity		☐	☐
Heart:	Enlargement, Arrhythmia, Murmur		☐	☐
Blood Pressure:	Systolic _____ Diastolic _____		☐	☐
Lungs:	Rales, Dullness, Chronic infection		☐	☐
Abdomen:	Enlargement, Hernia		☐	☐
Back:	Deformities, Range of motion		☐	☐
Extremities:	Deformities, Amputations, Motion Limitations, Varicose veins		☐	☐
Skin:	Disfigurement, Infection		☐	☐
Nervous:	Vasomotor instability, Neurological defect		☐	☐
Mental	Instability		☐	☐
Teeth:			☐	☐

Urinalysis: _____

Any symptoms or history of (Y or N):
Tuberculosis _____
_____Surgeries _____
Arthritis _____
Diabetes _____

Does applicant meet the physical requirements for this position? Yes ___ No ____

If not, list disqualifying defects: _____

_____

_____

Summary of findings: _____

_____

_____

_____ _____

Physician's Signature Date