Ohio Police & Fire Pension Fund
140 East Town Street
Columbus, OH 43215
Phone: 1-888-864-8363
www.op–f.org

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: Personal information

Name: First, MI, Last, suffix (Jr., III, etc.)

Social Security number

Street Address / Post office box

Date of Birth

City, State, ZIP code

Home phone

Alternate phone

Name of potential employer

Check one: ❑ MALE ❑ FEMALE

Check one: ❑ POLICE ❑ FIRE

Potential Date of Hire

Section B: Medical History

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

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

Check conditions you currently have or have had:

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

Please list allergy and reaction:

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

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

❑ **Alzheimer's disease:** If so, who?	❑ **High blood pressure:** If so, who?
❑ **Arthritis:** If so, who?	❑ **High cholesterol:** If so, who?
❑ **Asthma:** If so, who?	❑ **Lung disease:** If so, who?
❑ **Breast cancer:** If so, who?	❑ **Mental illness:** If so, who?
❑ **Colon cancer:** If so, who?	❑ **Stroke:** If so, who?
❑ **Other caners:** If so, who?	❑ **Thyroid disease:** If so, who?
❑ **Diabetes:** If so, who?	❑ **Tuberculosis (TB):** If so, who?
❑ **Heart disease:** 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 certifi cation, 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 identifi ed 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 fi le 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 profi le 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 certifi cation (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 certifi es 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 <u>no evidence</u>** of the existence of any heart disease, cancers, cardiovascular disease or respiratory disease.
(initial)

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

Diagnosis/conclusions:

Physican's name:	Phone number
Physician's street address / Post office box	
City, State, Zip Code	
Physician's signature:	Date of signature:

*(the signature of a nurse practitioner or physician's assistant is **not** valid on this certifi cation)*

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