

The [Genetic Information Nondiscrimination Act of 2008](#) (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Instructions:

- Fill out the questionnaire completely and accurately. Keep in mind that all statements are subject to verification; deliberate inaccuracies or incomplete statements may bar or remove you from employment. A "yes" answer does not necessarily mean that you will be disqualified.
- This form must be completed and presented when reporting for your medical examination.
- This medical history statement is confidential. If hired, the information you provide will be part of your medical record, separate from your personnel file.
- Type or legibly print (in ink), or complete this form online at www.post.ca.gov/forms.aspx.

SECTION 1. CANDIDATE IDENTIFICATION

1. CANDIDATE'S NAME (Last, First, Middle)		2. SOCIAL SECURITY NUMBER Last 4 digits:	3. BIRTHDATE (MM/DD/YYYY)
4. ADDRESS WHERE YOU CAN BE CONTACTED (Street / P.O. Box)		5. CITY	6. STATE / ZIP
7. PHONE NUMBERS WHERE YOU CAN BE REACHED Day: () - Evening: () -		8. EMAIL	

SECTION 2. JOB HISTORY

9. List current and all previous jobs held in the last 5 years, including military service.

JOB TITLE	PRIMARY DUTIES	EMPLOYER	APPROXIMATE DATES
A)			From: _____ To: _____
B)			From: _____ To: _____
C)			From: _____ To: _____
D)			From: _____ To: _____
E)			From: _____ To: _____
F)			From: _____ To: _____
G)			From: _____ To: _____

SECTION 3. MEDICAL HISTORY

Y	N	?	Answer each of the following questions.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Have you ever worked as a public safety dispatcher before?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever failed to complete a public safety dispatcher training program?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever failed a pre-placement medical examination?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever been refused employment or been unable to hold a job because of any physical, psychological, or other medically-related reason?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Are you currently under a health care provider's care for any medical condition?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you have any physical limitations?

MEDICAL HISTORY STATEMENT – Public Safety Dispatcher

POST 2-264 (Rev 02/2013)

SECTION 4. MEDICAL CONDITIONS											
Indicate if you have, or ever had, any of the following conditions. If you're unsure, mark "?"											
	Y	N	?		Y	N	?		Y	N	?
36. EYE, EAR, NOSE, THROAT											
A) Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E) Abnormal color vision test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I) Ear surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Need to wear corrective lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Refractive surgery (e.g., Lasik, PRK)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	J) Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Blurred or double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G) Ringing or buzzing in ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	K) Abnormal hearing test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H) Hearing trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. GASTROINTESTINAL											
A) Ulcer / stomach trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E) Mucous in stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I) Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Persistent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Black / bloody bowel movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	J) Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G) Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) Recurrent hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H) Abnormal liver test / liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. GENITOURINARY											
A) Kidney disease or stone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C) Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E) Menstrual discomfort that kept you from work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D) Prostatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. CARDIOVASCULAR											
A) Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C) Palpitation (irregular heartbeat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E) Pain or discomfort in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D) High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Swelling of foot or leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. MUSCULOSKELETAL											
A) Back trouble/pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	B) Neck trouble / Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C) Arthritis / Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. JOINT INJURY / SURGERY / DISLOCATION / PAIN / SWELLING											
A) Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D) Fingers / Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G) Ankle / Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E) Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. NEUROLOGICAL											
A) Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F) Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	K) Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Convulsion / Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G) Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L) Meningitis / Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Fainting spells / Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H) Frequent / recurrent headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M) Numbness of extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I) Migraine / Sinus headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N) Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E) Recurrent dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	J) Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. MISCELLANEOUS											
A) Diabetes (glucose in urine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G) Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M) Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Low blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H) Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N) Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Thyroid trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I) Undesired weight loss or gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O) Sleep problems / disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	J) Multiple chemical sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P) Chronic or frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E) Cancer / Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	K) Recurrent fever in the last year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Q) Any other problem or illness not listed that may affect job performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F) Non-healing sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L) Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

