CITY OF ESPAÑOLA
EMPLOYEE HEALTH STATEMENT

NAME (Last) (First) (Initial) DATE OF BIRTH

Have you ever had any of the following? (Please check NO or YES for each item and indicate approximate dates for YES replies)

	YES	NO	DATE
Respiratory Problems			
Back Trouble			
Diabetes			
Epilepsy			

	YES	NO	DATE
Fainting/Dizziness			
Heart Trouble			
High Blood Pressure			
Hernia			

Have you had any serious injuries: _____ NO _____ YES If YES, describe and indicate date of injury:

Injury: _____ Date: _____
Injury: _____ Date: _____
Injury: _____ Date: _____
Injury: _____ Date: _____

Have you ever been treated in a hospital or in a Physician's or Chiropractor's office for a bone, joint or muscle problem?
_____ NO _____ YES If YES, describe below:

COMPLAINT/INJURY	**WHEN**	**WHERE**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had an injury at work covered by Workmen's Compensation? ____ NO ___ YES
If YES, describe below.

INJURY	**WHEN**	**EMPLOYER**
_____	_____	_____
_____	_____	_____

Was permanent disability awarded? _____ NO _____ YES If YES, please describe disability and give percentage:
_____

EMERGENCY INFORMATION:
Are you allergic to any drugs? ____ NO _____ YES If YES, what? _____
Are you currently taking any medication(s)? ____ NO _____ YES If YES, what? _____
Who is your personal physician? _____
What person should we notify in case of an emergency? _____
Phone _____ Address _____ Relationship _____

_____
Signature Date