NEW JERSEY STATE POLICE
2018
Physician Authorization to Participate in Physical Agility Testing (C20)

Dear Physician:

The following named individual is a New Jersey State Trooper:
(Name & Address must be completed by Trooper)

Name: ______________________________ Badge #: __________

Address: ______________________________

The New Jersey State Police require Troopers to participate in an annual physical fitness program. Prior to participation, Troopers are required to receive an annual medical examination from a treating physician of their choosing. Troopers are encouraged to see their own primary care physician with whom they already have a relationship.

The NJ State Health Benefits Program (SHBP) will cover the cost of this requirement as an annual physical based upon the agreement between the participating physician and the insurance carrier.

Note: Letters of agreement from the two SHBPs (NJPlus and Aetna) are included and Troopers are to provide a copy to their primary care physician.

Before a Trooper is permitted to participate in the physical fitness program, a statement must be obtained from a licensed physician stating that the Trooper can safely participate. Therefore, we ask that you administer/ review all medical documents and tests, and the attached description of the New Jersey State Police Physical Agility Test prior to marking the applicable statement below:

PHYSICIAN'S STATEMENT ***(MUST check one box)***

☐ I have reviewed the results of **ALL** medical documents and tests (as delineated above), as well as the attached description of the New Jersey State Police Physical Agility Test, and find the above named Trooper can safely participate in the program.

☐ I have reviewed the results of **ALL** medical documents and tests (as delineated above), as well as the attached description of the New Jersey State Police Physical Agility Test, and find the above named Trooper cannot safely participate in the program.

Date Examined by Physician: __________________

______________________________ __________________
Physician's Signature *Date*

Please type or print:

Physician's Name: ______________________________ Telephone: **732-969-2240**

Address: **835 Roosevelt Ave., Carteret, NJ 07008**

Physician's License Number: ______________________________

This form is valid for one year from date of physician's examination

NOTE: Any misrepresentation or omission of required documents may preclude a Trooper from participating in the State Police Physical Fitness Program. Questions of a medical nature may be directed to the Medical Services Unit at (609) 882-2000 ext. 2540.

S.P. 116 (Rev. 12/17)

FOR OFFICIAL USE ONLY

YEAR

BADGE

HAS PARTICIPATION BEEN AUTHORIZED? ☐ YES ☐ NO

NEW JERSEY STATE POLICE

Annual Medical History Form

Trooper to Complete:

DATE: / /	BADGE #:	NAME: *First* *Last* *MI*			
GENDER: ☐ Female ☐ Male	AGE: *Years*	DATE OF BIRTH: / /	CURRENT WEIGHT: *lbs.*	CURRENT HEIGHT: *feet* *inches*	BMI:
UNIT CODE:	ASSIGNMENT:		SUPERVISOR:		
HOME PHONE: ( ) -	WORK PHONE: ( ) - *ext.:*		CELL PHONE: ( ) -		

Military Overseas Deployment? ☐ YES ☐ NO

If YES, describe any related symptoms you are experiencing:

Medication/Supplements? ☐ YES ☐ NO

(List all, including doses and frequency):

Allergies? ☐ YES ☐ NO

(List all, Food or Medications):

Medical History

Trooper to Complete:

NAME: *First*	*Last*	*MI*	BADGE #

Personal Medical History for the Previous 365 Days

Head/Neck

- ☐ Head Trauma
- ☐ Concussion
- ☐ Dizzy Spells/Seizures
- ☐ Fainting
- ☐ Headaches/Migraine
- ☐ Neck Injuries
- ☐ Other ____________

Eyes

- ☐ Blurred Vision
- ☐ Change in Vision
- ☐ Color Deficiency
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Eye Surgery/Lasik
- ☐ Flashes of Light
- ☐ Glasses/Contacts
- ☐ Partial Loss of Vision
- ☐ Other ____________

Last Eye Exam: ____________

Ears

- ☐ Decrease in Hearing
- ☐ Difficulty Clearing Sinuses/Ears
- ☐ Discharge
- ☐ Frequent Earache
- ☐ Frequent Itching in Ears
- ☐ Hearing Aid
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Ruptured Eardrum
- ☐ Other ____________

Nose/Throat

- ☐ Bleeding Gums
- ☐ Difficulty Swallowing
- ☐ Enlarged Glands
- ☐ Fractured Nose
- ☐ Frequent Sinusitis
- ☐ Frequent Sore Throats
- ☐ Loss of Smell
- ☐ Nose Bleeds
- ☐ Persistent Hoarseness
- ☐ Other ____________

Heart/Circulation

- ☐ Angina
- ☐ Ankle/Leg Swelling
- ☐ Arrhythmia
- ☐ Chest Pain on Exertion
- ☐ Chest Pain, Pressure, or Tightness
- ☐ Heart Attack
- ☐ Heart Disease/Disorder
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Heart Valve Disorder
- ☐ High Blood Pressure
- ☐ Leg Cramp When Walking
- ☐ Night Cough
- ☐ Palpitations/Flutters
- ☐ Persistent Fatigue
- ☐ Radiating Chest Pain to Arms, Jaw, Neck, Back
- ☐ Shortness of Breath
- ☐ Shortness of Breath on Lying Down
- ☐ Varicose Veins
- ☐ Rigid/Irregular Pulse
- ☐ Other ____________

Gastrointestinal

- ☐ Abdominal Pain after Meals
- ☐ Bariatric Surgery
- ☐ Bloating/Gas/Cramping
- ☐ Bloody or Painful BM
- ☐ Change in Bowel Habits
- ☐ Weight Loss
- ☐ Food Intolerance
- ☐ Heartburn/Indigestion
- ☐ Hemorrhoids
- ☐ Hiatal Hernia
- ☐ History of Polyps
- ☐ Nausea/Vomiting
- ☐ Change in Size of Stool
- ☐ Persistent Diarrhea
- ☐ Reflux
- ☐ Other ____________

Urinary

- ☐ Blood in Urine
- ☐ Burning on Urination
- ☐ Difficulty Starting/Stopping
- ☐ Dripping
- ☐ Erectile Dysfunction
- ☐ Kidney/Bladder Stones
- ☐ Nighttime Frequency
- ☐ Sexually Transmitted Disease
- ☐ Other ____________

Lungs

- ☐ Abnormal Chest X-ray
- ☐ Asbestosis Exposure
- ☐ Asthma/Wheezing
- ☐ Chest Pain with Deep Breath
- ☐ Chronic Bronchitis
- ☐ Chronic Cough
- ☐ Cough when Lying Down
- ☐ Coughing at Night
- ☐ Coughing Blood in Last Month
- ☐ Daytime Drowsiness
- ☐ Early Morning Cough
- ☐ Emphysema
- ☐ Night Sweats
- ☐ Pneumonia/Pleurisy
- ☐ Pneumothorax/Collapsed Lungs
- ☐ Productive Cough
- ☐ Shortness of Breath
- ☐ Shortness of Breath while walking fast or up slight incline
- ☐ Shortness of Breath while walking with others at ordinary pace on level ground
- ☐ Shortness of Breath while washing/dressing
- ☐ Shortness of Breath that interferes with job
- ☐ Occupational Exposure
- ☐ Snoring
- ☐ Shortness of Breath while walking at your own pace on level ground
- ☐ Tuberculosis
- ☐ Prescribed Inhalers
- ☐ Other ____________

Menstrual History

- ☐ Abnormal Pap
- ☐ Anemia
- ☐ Breast Lumps
- ☐ Heavy Bleeding
- ☐ Hot Flashes/Sweats
- ☐ Irregular Cycle
- ☐ Pregnancy Complication
- ☐ Severe Cramping
- ☐ Spotting
- ☐ Vaginal Discharge
- ☐ Other ____________

Spine/Extremities

- ☐ Amputation
- ☐ Backache/Injury
- ☐ Difficulty Bending at the knees
- ☐ Difficulty Climbing a flight of stairs or ladder carrying more than 25 lbs
- ☐ Difficulty Fully Moving Your Head Up/Down
- ☐ Difficulty Fully Moving Your Head Side to Side
- ☐ Difficulty Squatting to Ground
- ☐ Dislocation
- ☐ Fractures
- ☐ Joint Pain
- ☐ Joint Swelling/redness/heat
- ☐ Sprain/Strains
- ☐ Weakness of Hands/Feet
- ☐ Numbness/tingling of Extremities
- ☐ Other ____________

Have you had injuries to the following:

- ☐ Ankle
- ☐ Elbow
- ☐ Foot
- ☐ Hand
- ☐ Knee
- ☐ Ligament
- ☐ Neck
- ☐ Shoulder
- ☐ Tendon
- ☐ Other ____________

Thyroid

- ☐ Brittle Nails/Hair
- ☐ Decease/Increase in Appetite
- ☐ Goiter
- ☐ Hand Tremor
- ☐ Heat/Cold Intolerance
- ☐ Rapid/Slow Heartbeat
- ☐ Thyroid Nodule
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Other ____________

Substances

- ☐ Smoke Cigarettes
  - Packs per day ________
- ☐ Smoke Cigars
  - Number per day ________
- ☐ Chew Tobacco
  - Amount per day ________
- ☐ Drug dependency
- ☐ Treatment for Alcoholism
- ☐ Other ____________

Medical History
Trooper to Complete:

NAME: *First*	*Last*	*MI*	BADGE #

Do you currently have or have you ever had:

Coronary Artery Disease

- [ ] Aspirin ____
- [ ] Other anti-platelet meds (Plavix/Ticlid/Coumadin) ____
- [ ] Beta Blockers (Teprol, Coreg, etc.) ____
- [ ] Ace Inhibitor ____
- [ ] Stent ____
- [ ] CABG
- [ ] Angioplasty

Diabetes

- [ ] HgbA1c Last ____
- [ ] Statins use ____
- [ ] FBS last ____
- [ ] Aspirin ____

Medical Tests *(Provide Dates if Applicable)*

- [ ] CAT Scan ____
- [ ] Cardiac Catheterization ____
- [ ] Chemotherapy ____
- [ ] Chest X-ray ____
- [ ] Coronary CTA ____
- [ ] EKG ____
- [ ] MRI ____
- [ ] Mammogram ____
- [ ] PAP ____
- [ ] PSA ____
- [ ] Radiation Therapy ____
- [ ] Stress Test ____
- [ ] Ultrasound ____
- [ ] Other ____

Have you been told to have any procedures that you have not had done? ☐ YES ☐ NO *If yes, list below:*

Surgeries *(Type and Date)*

Health Screening

Do you sometimes drink beer, wine, or other alcoholic beverages?
☐ Yes ☐ No

How many times in the past year have you had:
(Men) 5 or more drinks in a day? ____
(Women) 4 or more drinks in a day? ____

On average, how many days a week do you have an alcoholic drink? ____
On a typical drinking day, how many drinks do you have? ____

In the past 12 months has your drinking repeatedly caused or contributed to:

- [ ] Risk of bodily harm (eg., while operating machinery, swimming, etc.)
- [ ] Relationship trouble (family or friends)
- [ ] Role failure (eg., interference with home, work, parental or marital relationships)
- [ ] Trouble with administrative, financial or legal issues

In the past 12 months have you:

- [ ] Not been able to limit your drinking when you tried to?
- [ ] Not been able to cut down or stop?
- [ ] Needed to drink a lot more to get the same effect?
- [ ] Experienced tremors, nausea, sweating or insomnia when trying to quit or cut down?
- [ ] Kept drinking despite problems - physical or psychological?
- [ ] Spent a lot of time planning your drinking or recovering from drinking?
- [ ] Spent less time on activities that are usually important or pleasurable to you?
- [ ] Do people notice that you snore loudly or frequently?
- [ ] Do you experience gasping or choking spells at night?
- [ ] Do people notice that you stop breathing while sleeping?
- [ ] Do you have trouble with sleepiness during the daytime?
- [ ] Do you have trouble with sleepiness while driving?

During the past month

Have you often been bothered by feeling down, depressed or hopeless? ☐ Yes ☐ No
Have you often been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that in the past month you:

Have had nightmares about it or thought about it when you did not want to? ☐ Yes ☐ No
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? ☐ Yes ☐ No
Were constantly on guard, watchful, or easily startled? ☐ Yes ☐ No
Felt numb or detached from others, activities, or your surroundings? ☐ Yes ☐ No

Medical Examination

Physician to Complete:

NAME: *First*	*Last*	*MI*	BADGE #

Examination	Findings/Comments
BLOOD PRESSURE: ________ If Systolic >140, serial pressures to be taken Ht. ________ Wt. ________	
HEAD: Symmetry or deformity ________	
NECK: Nodes: ________	
EYES: Pupils round, regular, react to light and accommodations ________ **Vision:** Corrected ☐ OD ☐ OS ☐ OU Uncorrected ☐ OD ☐ OS ☐ OU	
EARS: Otoscopic visualization of eardrums ________	
NOSE: ________	
THROAT: Thyroid ________	
CHEST: ________	
HEART: Rate: ________ Rhythm: ________ Murmur: ________	
CIRCULATION: Pulses ________	
SKIN: Melanoma ________	
MUSCULOSKELETAL: ________	
ABDOMEN: ________	
NEUROLOGICAL: ________	
RECTAL: ________	
GENITALIA: ________	

Medical Examination

Physician to Complete:

NAME: *First*	*Last*	*MI*	BADGE #

Review of Medical History, Examination and All Testing

EKG Reviewed ☐ Yes ☐ No

Abnormal findings ☐ Yes ☐ No

Describe:____

Labwork Reviewed: ☐ Yes ☐ No

Abnormal findings *(list)*:____

Audiogram Reviewed: ☐ Yes ☐ No

Summary of Findings:

Recommendations:

____________	________________________	____________
Date	*Signature of Trooper*	*Badge No.*
Date	*Signature of Examining Physician*	*Physician's I.D. No.*