NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE HEALTH SERVICE

Appointment Checklist & Instructions for Required Forms

Correction Officer/ Correction Officer Trainee

EHS-10-C (9/2025)

- **Dress comfortably but appropriately:** You do not need to be dressed in professional attire for this appointment. Wearing comfortable, loose-fitting clothing to your appointment is recommended. This will allow the necessary examinations to be conducted more easily.

- **Please DO NOT bring large purses, totes, backpacks or luggage** to your appointment *(if it can be avoided).* The only items needed for your EHS appointment are your photo ID and the two forms listed below (EHS-722 and EHS-728B). EHS is not responsible for lost or stolen personal items.

  ☐ **PHOTO ID** – Driver License, Passport, Government ID. MUST display your legal name, have an identifiable photo and cannot be expired.

- **PRINT and COMPLETE and BRING the attached forms to your appointment:**

  ☐ **EHS-722 Client Data & Consent Form** - Begin at "LAST NAME" and complete the whole section titled "Client Should Complete This Area (please print clearly)". If you do not have a home phone number, please draw a line through the box. IF you are presently employed by New York State (NOT a County, City, or School), complete the next section. In the bottom section, initial that you have received the EHS-808 "Notice of Privacy Practices" (2015) and check the box next to "Pre-Employment Candidates Only". Enter your email address, one letter/number/symbol per short line. Sign at "Client's Signature" and enter the Date.

  ☐ **EHS-728B Medical History Questionnaire for Preplacement Examinations** - Begin at Name and complete the ENTIRE packet. When you get to page 12, please Sign and Date ONCE on the "FIRST UPDATE" line ONLY.

- **IF you wear contacts and/or glasses:** If you have corrected vision, you must bring your glasses (if you have them) and/or your contact lenses plus a lens case with solution in order to perform corrected vision vs. uncorrected vision test.

  ☐ **Contact Lenses, Contact Lens Case, Contact Lens Solution** – If you wear contacts.

  ☐ **Prescription Glasses** – If you have prescription glasses.

- **READ and KEEP:** Read carefully and keep for your records. DO NOT bring these forms with you to your appointment.

  ☐ **EHS-808 Notice of Privacy Practices**

  ☐ **EHS-PM-11 Statement of Physical & Medical Requirements**

If you have any questions, please call Civil Service Employee Health Services at 518-233-3100 or the DOCCS Employee Investigation Unit at 518-485-9500.

Client #_____ **Verification of Client ID**_____

NEW YORK STATE | **Department of Civil Service**

EMPLOYEE HEALTH SERVICE
Client Data and Consent for Medical Examination

EHS-722 (9/2024L)

FOR EHS OFFICE STAFF ONLY:

TYPE OF EXAMINATION:

OH #_____ - _____ ☐ **REINSTATEMENT** ☐ **55 B/C**

☐ **AGENCY REFERRAL** ☐ **PRE-PLACEMENT** ☐ **OTHER**_____

TYPE OF TESTS:

☐ **VS/MD**	☐ **COMP.**	☐ **PULMONARY**	☐ **ASB. F/U**	☐ **URINE DRUG WITH**
☐ **NOISE**	☐ **LEAD**	☐ **CHOLINESTERASE**	☐ **ABILITY**	☐ **URINE DRUG WITHOUT**
☐ **ROUTINE BLOOD**	☐ **MMPI / BIO**	☐ **BLOOD ALCOHOL**	☐ **ASB/X-RAY**	☐ **PSYCH/OTHER**_____

CLIENT SHOULD COMPLETE THIS AREA (*Please print clearly*)

Last Name	*First Name*	*M.I.*	*SSN or EHS Acct No.*	*Date of Birth*	*Age*

Print any other last name by which you have been known:_____

Address Street	*Sex*
	☐ *Male* ☐ *Female*
City or Post Office *County* *State* *Zip Code*	*Cell Phone* ( )
Have you previously been examined by the Employee Health Service? ☐ *Yes* *If Yes, when?*_____ ☐ *No*	*Home Phone* ( )

FILL IN THIS SECTION ONLY IF YOU ARE CURRENTLY A STATE EMPLOYEE

Position Title (Either present or title that you are applying for.)	*State agency name and address where presently employed.*

CONSENT FOR EXAMINATION AND RELEASE OF MEDICAL INFORMATION

I hereby consent to receive a medical examination and authorize the New York State Department of Civil Service Employee Health Service, its personnel, medical staff and consultants to perform such medical examinations and diagnostic procedures as deemed necessary for evaluation and/or treatment of any health condition.

I authorize the Department of Civil Service to release or disclose the following medical information to the agency/facility where I am employed:

1. Confirmation or denial of my ability to participate in various workplace programs and/or to use personal protective gear.
2. Occupational-related outcomes or adverse health effects as a result of workplace exposures as required by O.S.H.A.

I received a copy of the EHS Notice of Privacy Practices _____ *(Initial here)*

☐ **Pre-employment Candidates Only – Check this box to authorize the electronic transfer of medical records. If your status becomes Remediable, we will send the Remediable instructions directly to your email. Please provide your email address below,**

__ __ __ __

THIS SIDE SHOULD BE COMPLETED BY THE EHS PROVIDER

PRE-PLACEMENT EXAMINATIONS – Final Disposition

- ☐ **Qualified** _____ **Examiner's Initials / Date**
- ☐ **Disqualified (see below)** _____ **Examiner's Initials / Date**
- ☐ **Incomplete (see below)** _____ **Examiner's Initials / Date**

ABILITY TEST: _____ **Passed** ☐ **N/A**

- ☐ **Failed first attempt**
- ☐ **Passed second attempt**
- ☐ **Failed second attempt - Disqualified**
- ☐ **Incomplete**

DRUG SCREEN: _____ **Negative** ☐ **N/A**

- ☐ **Needs MRO review**
- ☐ **MRO confirmed negative drug screen**
- ☐ **MRO confirmed positive drug screen - Disqualified**
- ☐ **Needs repeat drug screen**
- ☐ **Incomplete**

PSYCHOLOGICAL SCREEN: _____ **Passed** ☐ **N/A**

- ☐ **Needs psychological evaluation**
- ☐ **Cleared first psychological evaluation**
- ☐ **Not cleared first psych eval. – Schedule 2nd evaluation**
- ☐ **Cleared second psychological evaluation**
- ☐ **Not cleared 2nd evaluation - Disqualified**
- ☐ **Incomplete**

MEDICAL EVALUATION: _____ **Passed**

- ☐ **Remediable:**
- **#1** _____ ☐ **Cleared**
- **#2** _____ ☐ **Cleared**
- **#3** _____ ☐ **Cleared**
- **#4** _____ ☐ **Cleared**
- ☐ **Disqualified**
- ☐ **Incomplete**

FOLLOWING REPORTS TO BE SENT

EHS-797 Letter:

- ☐ **"Within Normal Limits" Letter**
- ☐ **"Discuss with Physician" Letter**
- ☐ **Client**_____
- ☐ **No Letter/Reports to be Sent**

NOTES:

- ☐ **Blood Chemistry/Hematology/Urinalysis**
- ☐ **Chest X-ray (Rpt.)**
- ☐ **ECG**
- ☐ **Hearing**
- ☐ **Physical Exam (including vital signs)**
- ☐ **Pulmonary Function**
- ☐ **Vision**
- ☐ **Other**

Examiner's Initials: _____ **Date:** _____

Reports Sent By: Initials: _____ **Date:** _____

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE HEALTH SERVICE
Medical History Questionnaire
for Preplacement Examinations

EHS-728B (3/2024)

Name	***Date***
Job Title which you are applying for	***Social Security Number***
	/ /

The medical examiner's evaluation of your health status and ability to perform the duties of a State job title is based upon knowledge of your complete medical history. This medical history questionnaire is designed to provide the examining physician with the information necessary to determine your ability to perform the essential duties of the State job title you are applying for.

INSTRUCTIONS

We encourage you to complete the entire questionnaire and answer to the best of your ability.

This booklet is made up of many questions most of which can be answered by simply checking the appropriate box or filling in the requested information.

Some questions, however, require you to answer additional questions, depending on your original response. For example, a question may read: Have you ever smoked? If you have not, then that finishes the question. If you have, then additional questions concerning smoking are asked.

Personal Privacy Protection Law Notification

The information you are providing on this questionnaire is being requested for the principal purpose of conducting an evaluation of your health with reference to a confidential profile of your medical history. It is being collected and maintained as a result of your voluntary request for an examination or pursuant to Section 50 of the Civil Service Law. This information will be used in accordance with Section 96(1) of the Personal Privacy Protection Law. Failure to provide this information may prevent the Employee Health Service from making such an evaluation. This information will be maintained by the Administrator, Employee Health Service, Department of Civil Service, 55 Mohawk Street – Suite 201, Cohoes, New York 12047; telephone (518) 233-3100. For further information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

PLEASE PRINT

MEDICATIONS

Please list all **Medications** below:

_____ dosage:_____ how often:_____
_____ dosage:_____ how often:_____
_____ dosage:_____ how often:_____
_____ dosage:_____ how often:_____
_____ dosage:_____ how often:_____
_____ dosage:_____ how often:_____
_____ dosage:_____ how often:_____

MEDICAL DIAGNOSES

Please list all **Medical Diagnoses/Conditions**:

_____
_____
_____
_____
_____
_____
_____

OCCUPATIONAL HISTORY

1. Current job title:_____

2. How long at this job?_____

3. Describe the duties of the job: _____

_____

4. Have you ever been injured at work? If ***YES***, explain: ☐ ***YES*** ☐ ***NO***

_____

_____

5. Have you ever received compensation for any illness or injury which developed on the job? ☐ ***YES*** ☐ ***NO***

If ***YES***, explain:_____

6. Have you ever been rejected for a job for health reasons? If ***YES***, explain: ☐ ***YES*** ☐ ***NO***

_____

_____

7. Have you ever left a job because of your health? If ***YES***, explain: ☐ ***YES*** ☐ ***NO***

_____

_____

8. Have you ever been limited in performing any types of work duties, either civilian or military because of your health? If ***YES***, explain: ☐ ***YES*** ☐ ***NO***

_____

_____

_____

9. Have you ever ***been*** in the military service? ☐ ***YES*** ☐ ***NO***

10. If you were in the military service, do you have a medical discharge? If ***YES***, explain: ☐ ***YES*** ☐ ***NO***

_____

_____

11. Have you ever been rejected from military service? If ***YES***, explain: ☐ ***YES*** ☐ ***NO***

_____

_____

12. Are you receiving or have you received any type of disability payment? If ***YES***, explain: ☐ ***YES*** ☐ ***NO***

_____

_____

SOCIAL HISTORY

13. **a**. Have you ever vaped or used an electronic cigarette? ☐ ***YES*** ☐ ***NO***

b. Have your ever smoked tobacco? If ***YES***, answer questions 14-18. If ***NO***, proceed to question 19. ☐ ***YES*** ☐ ***NO***

14. For how many years of your life have your smoked?_____

15. Do you currently smoke tobacco, or have you smoked tobacco in the last month? ☐ ***YES*** ☐ ***NO***

16. Do you currently smoke cigarettes? If ***YES***, how many cigarettes to you smoke? ☐ ***YES*** ☐ ***NO***

- ☐ Less than 1 pack per day
- ☐ One pack per day
- ☐ One to two packs per day
- ☐ More than two packs per day

17. Do you smoke cigars? ☐ ***YES*** ☐ ***NO***

18. Do you smoke a pipe? ☐ ***YES*** ☐ ***NO***

19. Do you drink beer? If ***YES***, how many glasses do you drink per day? ☐ ***YES*** ☐ ***NO***

- ☐ Drink beer only occasionally
- ☐ One to two glasses per day
- ☐ Three to four glasses per day
- ☐ More than four glasses per day

20. Do you drink wine, whiskey, or cocktails? If ***YES***, how much do you drink per day? ☐ ***YES*** ☐ ***NO***

- ☐ Drink wine, whiskey, or cocktails only occasionally
- ☐ One to two glasses (or shots) per day
- ☐ Three to four glasses (or shots) per day
- ☐ More than four glasses (or shots) per day

21. Do you ever drink alcoholic beverages in the morning? ☐ ***YES*** ☐ ***NO***

22. Have your ever gone to an alcohol detox/rehabilitation facility? If ***YES***, where, and when? ☐ ***YES*** ☐ ***NO***

_____

23. Have you ever been diagnosed with alcoholism? ☐ ***YES*** ☐ ***NO***

24. Have you ever used marijuana? If ***YES***, what was the approximate date of your last use?_____ ☐ ***YES*** ☐ ***NO***

25. Have you ever used other illegal drugs? If ***YES***, list names of the drugs used: ☐ ***YES*** ☐ ***NO***

_____

What was the approximate date you last used these drugs?_____

26. Have you ever abused prescription drugs? If ***YES***, list names of drugs abused: ☐ ***YES*** ☐ ***NO***

_____

What was the approximate date you last used these prescription drugs?_____

27. Have you ever gone to a drug rehabilitation facility? If ***YES***, when, and where? ☐ ***YES*** ☐ ***NO***

_____

28. Have you ever been diagnosed with drug addiction? If ***YES***, what drug(s): ☐ ***YES*** ☐ ***NO***

_____

CHIEF HEALTH COMPLAINT

29. Do you have any existing medical problem which would interfere with your ability to perform the essential duties of the position you are applying for? If ***YES***, describe briefly: ☐ ***YES*** ☐ ***NO***

_____

_____

30. Have you consulted a physician regarding the above complaint? If ***YES,*** describe briefly: ☐ ***YES*** ☐ ***NO***

_____

_____

MEDICAL HISTORY

31. Have you ever had any of the following conditions?

- Seizures If YES: Last Episode/s: date:_____ date:_____ date:_____ ☐ ***YES*** ☐ ***NO***
- Diabetes ☐ ***YES*** ☐ ***NO***
- Allergic reactions that interfere with your breathing ☐ ***YES*** ☐ ***NO***
- Claustrophobia (fear of closed-in places) ☐ ***YES*** ☐ ***NO***
- Trouble smelling odors ☐ ***YES*** ☐ ***NO***

If ***YES***, please explain any conditions which you checked above:

_____

_____

32. Have you ever had any of the following pulmonary or lung problems?

- Asbestosis ☐ ***YES*** ☐ ***NO***
- Asthma ☐ ***YES*** ☐ ***NO***
- Chronic bronchitis ☐ ***YES*** ☐ ***NO***
- Emphysema ☐ ***YES*** ☐ ***NO***

- Pneumonia ☐ ***YES*** ☐ ***NO***
- Tuberculosis ☐ ***YES*** ☐ ***NO***
- Silicosis ☐ ***YES*** ☐ ***NO***
- Pneumothorax (collapsed lung) ☐ ***YES*** ☐ ***NO***
- Lung Cancer ☐ ***YES*** ☐ ***NO***
- Broken ribs ☐ ***YES*** ☐ ***NO***
- Any chest injuries or surgeries ☐ ***YES*** ☐ ***NO***
- Any other lung problem that you've been told about. ☐ ***YES*** ☐ ***NO***

If ***YES***, please explain any conditions which you checked above:

_____

_____

33. Do you currently have any of the following symptoms of pulmonary or lung illness?

- Shortness of breath ☐ ***YES*** ☐ ***NO***
- Shortness of breath when walking fast on level ground or walking up a slight hill or incline ☐ ***YES*** ☐ ***NO***
- Shortness of breath when walking with other people at an ordinary pace on level ground ☐ ***YES*** ☐ ***NO***
- Have to stop for breath when walking at your own pace on level ground ☐ ***YES*** ☐ ***NO***
- Shortness of breath when washing or dressing yourself ☐ ***YES*** ☐ ***NO***
- Shortness of breath that interferes with your job ☐ ***YES*** ☐ ***NO***
- Coughing that produces phlegm (thick sputum) ☐ ***YES*** ☐ ***NO***
- Coughing that wakes you early in the morning ☐ ***YES*** ☐ ***NO***
- Coughing that occurs mostly when you are lying down ☐ ***YES*** ☐ ***NO***
- Coughing up blood in the last month ☐ ***YES*** ☐ ***NO***
- Wheezing ☐ ***YES*** ☐ ***NO***
- Wheezing that interferes with your job ☐ ***YES*** ☐ ***NO***
- Chest pain when you breathe deeply ☐ ***YES*** ☐ ***NO***
- Difficulty breathing while sleeping ☐ ***YES*** ☐ ***NO***
- Waking frequently while sleeping ☐ ***YES*** ☐ ***NO***
- Any other symptom that you think may be related to lung problems ☐ ***YES*** ☐ ***NO***

If ***YES***, please explain any conditions which you checked above:

_____

_____

34. Have you ever had any of the following cardiovascular or heart problems?

- Heart Attack ☐ ***YES*** ☐ ***NO***
- Stroke ☐ ***YES*** ☐ ***NO***
- Angina ☐ ***YES*** ☐ ***NO***
- Heart failure ☐ ***YES*** ☐ ***NO***
- Swelling in your legs or feet (not caused by walking) ☐ ***YES*** ☐ ***NO***
- Heart arrhythmia (heart beating irregularly) ☐ ***YES*** ☐ ***NO***
- High blood pressure ☐ ***YES*** ☐ ***NO***
- Any other heart problem that you've been told about ☐ ***YES*** ☐ ***NO***

If ***YES***, please explain any conditions which you checked above:

_____

_____

35. Have you ever had any of the following cardiovascular or heart symptoms?

- Frequent pain or tightness in your chest ☐ ***YES*** ☐ ***NO***
- Pain or tightness in your chest during physical activity ☐ ***YES*** ☐ ***NO***
- Pain or tightness in your chest that interferes with your job ☐ ***YES*** ☐ ***NO***
- In the past two years, have you noticed your heart skipping or missing a beat ☐ ***YES*** ☐ ***NO***
- Heartburn or indigestion that is not related to eating ☐ ***YES*** ☐ ***NO***
- Any other symptoms that you think may be related to heart or circulation problems ☐ ***YES*** ☐ ***NO***

If ***YES***, please explain any conditions which you checked above:

_____

_____

36. Do you currently take medication for any of the following problems? Please list on Page one.

- Breathing or lung problems ☐ ***YES*** ☐ ***NO***
- Heart trouble ☐ ***YES*** ☐ ***NO***
- Blood pressure ☐ ***YES*** ☐ ***NO***
- Seizures ☐ ***YES*** ☐ ***NO***

If ***YES***, please explain any conditions which you checked above:

_____

_____

37. Have you ever lost vision in either eye (temporarily or permanently)? If ***YES***, please explain ☐ ***YES*** ☐ ***NO***

_____

_____

38. Do your currently have any of the following vision problems?

- Wear contact lenses ☐ ***YES*** ☐ ***NO***
- Wear glasses ☐ ***YES*** ☐ ***NO***
- Color blind ☐ ***YES*** ☐ ***NO***
- Any other eye or vision problem ☐ ***YES*** ☐ ***NO***

If ***YES***, please explain any conditions which you checked above:

_____

_____

39. Have you ever had an injury to your ears, including a broken ear drum? If ***YES***, please explain ☐ ***YES*** ☐ ***NO***

_____

40. Do you currently have any of the following hearing problems?

- Difficulty hearing ☐ ***YES*** ☐ ***NO***
- Wear a hearing aid ☐ ***YES*** ☐ ***NO***
- Any other hearing or ear problem ☐ ***YES*** ☐ ***NO***

If ***YES***, please explain any conditions which you checked above:

_____

_____

41. Have you ever had a back injury? If ***YES***, please explain: ☐ ***YES*** ☐ ***NO***

_____

42. Do you currently have any of the following musculoskeletal problems?

- Weakness in any of your arms, hands, legs, or feet ☐ ***YES*** ☐ ***NO***
- Back pain ☐ ***YES*** ☐ ***NO***
- Difficulty fully moving your arms and legs ☐ ***YES*** ☐ ***NO***
- Pain or stiffness when you lean forward or backward at the waist ☐ ***YES*** ☐ ***NO***
- Difficulty fully moving your head up or down ☐ ***YES*** ☐ ***NO***
- Difficulty fully moving your head side to side ☐ ***YES*** ☐ ***NO***
- Difficulty bending at your knees ☐ ***YES*** ☐ ***NO***
- Difficulty squatting to the ground ☐ ***YES*** ☐ ***NO***
- Difficulty climbing a flight of stair or a ladder carrying more than 25 lbs. ☐ ***YES*** ☐ ***NO***
- Any other muscle or skeletal problem that interferes with using a respirator or working ☐ ***YES*** ☐ ***NO***

If you answered ***YES***, please explain any conditions which you checked above:

_____

_____

43. Other than medications for breathing and lung problems, heart trouble, blood pressure and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medication)? If ***YES***, name the medications, if you know them: ☐ ***YES*** ☐ ***NO***

_____

Has a doctor ever told you that you had any of the following diseases or illnesses?

44. AIDS ☐ ***YES*** ☐ ***NO***
45. Arthritis or rheumatism ☐ ***YES*** ☐ ***NO***
46. Cancer ☐ ***YES*** ☐ ***NO***
47. Cataract ☐ ***YES*** ☐ ***NO***
48. Depression ☐ ***YES*** ☐ ***NO***
49. Epilepsy or frequent convulsions ☐ ***YES*** ☐ ***NO***
50. Glaucoma ☐ ***YES*** ☐ ***NO***
51. Heart murmur ☐ ***YES*** ☐ ***NO***
52. Hepatitis ☐ ***YES*** ☐ ***NO***
53. Hernia or rupture ☐ ***YES*** ☐ ***NO***
54. Hyperthyroid (overactive) ☐ ***YES*** ☐ ***NO***
55. Hypothyroid (underactive) ☐ ***YES*** ☐ ***NO***

56.	Jaundice	☐ *YES*	☐ *NO*
57.	Kidney or bladder disease	☐ *YES*	☐ *NO*
58.	Nervous breakdown	☐ *YES*	☐ *NO*
59.	Nervous tension (anxiety)	☐ *YES*	☐ *NO*
60.	Other Psychiatric condition	☐ *YES*	☐ *NO*
61.	Paralysis	☐ *YES*	☐ *NO*
62.	Phlebitis or blood clots	☐ *YES*	☐ *NO*
63.	Polio	☐ *YES*	☐ *NO*
64.	Rheumatic fever	☐ *YES*	☐ *NO*
65.	Stroke or brain hemorrhage	☐ *YES*	☐ *NO*
66.	Sleep Apnea	☐ *YES*	☐ *NO*
	If YES, do you use a CPAP/ BIPAP	☐ *YES*	☐ *NO*

SURGERY HISTORY

67.	Have you ever had surgery? If ***YES***, complete the questions below:	☐ *YES*	☐ *NO*
a.	Artery or vein	☐ *YES*	☐ *NO*
b.	Back or spine	☐ *YES*	☐ *NO*
c.	Bones (fractures)	☐ *YES*	☐ *NO*
d.	Eyes	☐ *YES*	☐ *NO*
e.	Gastrointestinal system	☐ *YES*	☐ *NO*
f.	Heart	☐ *YES*	☐ *NO*
g.	Hernia (rupture)	☐ *YES*	☐ *NO*
h.	Joints	☐ *YES*	☐ *NO*
i.	Kidney, bladder, or prostate gland	☐ *YES*	☐ *NO*
j.	Lung	☐ *YES*	☐ *NO*
k.	Nervous system (brain)	☐ *YES*	☐ *NO*
l.	Sleep Apnea	☐ *YES*	☐ *NO*
	If YES, do you use a CPAP/BIPAP?	☐ *YES*	☐ *NO*

68. Have you had operations on other parts of your body not listed previously? If ***YES***, please specify below: ☐ *YES* ☐ *NO*

_____

_____

69. Have you ever been hospitalized other than for routine childbirth? If ***YES***, list below: ☐ *YES* ☐ *NO*

Year(s) Hospitalized:	**Reason:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

TUBERCULOSIS

70. Have you ever been in close contact with people who had or have Tuberculosis (TB)? ☐ ***YES*** ☐ ***NO***

Have you ever had a TB skin test? If ***YES***, (Date): _____ (Results):_____ ☐ ***YES*** ☐ ***NO***

Have your ever been treated to prevent TB? ☐ ***YES*** ☐ ***NO***

Have you ever been treated for active TB? ☐ ***YES*** ☐ ***NO***

CARDIOVASCULAR

71. Have you ever had an electrocardiogram (EKG) taken? ☐ ***YES*** ☐ ***NO***

If ***YES***, were you ever told by a physician that your EKG was abnormal in any way? If ***YES***, explain below: ☐ ***YES*** ☐ ***NO***

_____

_____

72. Do you frequently notice you develop pains or cramps in the calves of your legs while walking? If you answered ***"YES"***, then complete questions below: ☐ ***YES*** ☐ ***NO***

- Do the pains make you stop walking? ☐ ***YES*** ☐ ***NO***
- Do the pains go away when you rest a few minutes? ☐ ***YES*** ☐ ***NO***

73. Do your fingers usually become painful, numb, white, or blue when they get only slightly cold? ☐ ***YES*** ☐ ***NO***

74. Has the skin on your lower legs become dark in color? ☐ ***YES*** ☐ ***NO***

75. Do you often notice some swelling in both ankles? ☐ ***YES*** ☐ ***NO***

GASTROINTESTINAL

76. During the past year have you vomited blood or material that looked like coffee grinds? ☐ ***YES*** ☐ ***NO***

77. Do you often have bad pains in your stomach or abdomen? ☐ ***YES*** ☐ ***NO***

78. During the past year have you had blood in your stools or had black, tarry stools? ☐ ***YES*** ☐ ***NO***

79. Have you ever had gastrointestinal (stomach, intestines, colon) problems? If ***YES***, please explain: ☐ ***YES*** ☐ ***NO***

_____

_____

URINARY

80. Have you ever had kidney, prostate, or bladder problems? If ***YES***, please explain: ☐ ***YES*** ☐ ***NO***

_____

_____

NEUROLOGIC

81. Do you get severe dizzy spells? If ***YES***, then complete questions below: ☐ ***YES*** ☐ ***NO***

Are these spells associated with any of the following:

- Deafness ☐ ***YES*** ☐ ***NO***
- Ringing or noises in your ears ☐ ***YES*** ☐ ***NO***
- Nausea or vomiting ☐ ***YES*** ☐ ***NO***
- Staggering or difficulty walking ☐ ***YES*** ☐ ***NO***
- Taking deep breaths or having trouble getting enough air into your lungs ☐ ***YES*** ☐ ***NO***

How long do these dizzy spells usually last?_____

82. Do you have frequent headaches? If ***YES***, then complete questions below: ☐ ***YES*** ☐ ***NO***

- Headaches, for more than a year ☐ ***YES*** ☐ ***NO***
- Headaches, becoming more frequent ☐ ***YES*** ☐ ***NO***
- Headaches, becoming more severe ☐ ***YES*** ☐ ***NO***
- Headaches, lasting more than one hour ☐ ***YES*** ☐ ***NO***

Do these headaches usually occur:

- In the morning ☐ ***YES*** ☐ ***NO***
- In the afternoon ☐ ***YES*** ☐ ***NO***
- At night ☐ ***YES*** ☐ ***NO***

Do you sometimes have nausea and vomiting with the headaches? ☐ ***YES*** ☐ ***NO***

Do the headaches ever bother your vision? ☐ ***YES*** ☐ ***NO***

Do mild non-prescription medicines such as aspirin relieve these headaches? ☐ ***YES*** ☐ ***NO***

83. Have you ever fainted, passed out or been unconscious? If ***YES***, answer questions below: ☐ ***YES*** ☐ ***NO***

Was this caused by:

- An injury to your head ☐ ***YES*** ☐ ***NO***
- Drinking too much alcohol ☐ ***YES*** ☐ ***NO***
- Some upsetting situation ☐ ***YES*** ☐ ***NO***

How many spells have you had in the past year? _____

How long were you unconscious for? _____

<u>Have you had any of the following?</u>

84. Speech becoming slurred ☐ ***YES*** ☐ ***NO***
85. Difficulty writing as clearly as you used to ☐ ***YES*** ☐ ***NO***
86. Difficulty in buttoning your clothes ☐ ***YES*** ☐ ***NO***
87. Weakness in an arm or leg ☐ ***YES*** ☐ ***NO***
88. Frequently keyed up or jittery ☐ ***YES*** ☐ ***NO***
89. Trouble sleeping ☐ ***YES*** ☐ ***NO***
90. Take nerve medicine ☐ ***YES*** ☐ ***NO***
91. See a psychiatrist for nervous or upset condition ☐ ***YES*** ☐ ***NO***
92. Had other counseling for nervous or upset condition ☐ ***YES*** ☐ ***NO***
93. Have a fear of heights. ☐ ***YES*** ☐ ***NO***
94. Are you often depressed ☐ ***YES*** ☐ ***NO***

HEMATOLOGIC

95. Have you ever been told by a physician that you were anemic or that you had a low blood count? ☐ ***YES*** ☐ ***NO***

If ***YES***, do you take any medicine for this condition? ☐ ***YES*** ☐ ***NO***

96. Do you have bleeding tendencies or been diagnosed with a bleeding disorder? If ***YES***, please explain: ☐ ***YES*** ☐ ***NO***

_____

_____

97. Do you have an immune disorder? If ***YES***, please explain: ☐ ***YES*** ☐ ***NO***

_____

98. Have you ever had Blood Cancer/ Leukemia? ☐ ***YES*** ☐ ***NO***

If YES, are you seeing a Physician/Oncologist for this? ☐ ***YES*** ☐ ***NO***

99. ***Have you ever had Lymph Node and/or Blood Malignancy, or Hodgkin's disease?*** ☐ ***YES*** ☐ ***NO***

ENDOCRINE

100. During the last year have you noticed that you have excessive thirst and drink much more water and other liquids than you used to? ☐ ***YES*** ☐ ***NO***

101. Have you ever had sugar in your urine? ☐ ***YES*** ☐ ***NO***

102. Are you now pregnant? ☐ ***YES*** ☐ ***NO***

103. Are you menstruating today? ☐ ***YES*** ☐ ***NO***

RESPIRATOR USE

104. Have you ever used a respirator before? If ***YES***, have you ever had any of the following problems while using a respirator? ☐ ***YES*** ☐ ***NO***

- Eye irritation ☐ ***YES*** ☐ ***NO***
- Skin allergies or rashes ☐ ***YES*** ☐ ***NO***
- Anxiety ☐ ***YES*** ☐ ***NO***
- General weakness or fatigue ☐ ***YES*** ☐ ***NO***
- Any other problem that interferes with your use of a respirator ☐ ***YES*** ☐ ***NO***

If ***YES***, please explain any conditions which you checked above:

_____

_____

_____

PLEASE SIGN AND DATE QUESTIONNAIRE ONCE FOR INITIAL EVALUATION.

Additional (Second and Third Updates) are for future appointments shall you return to EHS.

PLEASE SIGN AND DATE QUESTIONNAIRE

FIRST UPDATE: ***Signature:*** _____ ***Date:*** _____

SECOND UPDATE: ***Signature:*** _____ ***Date:*** _____

THIRD UPDATE: ***Signature:*** _____ ***Date:*** _____

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE HEALTH SERVICE

Notice of Privacy Practices

EHS-808 (2015)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

Who Will Follow This Notice:

This notice describes the Department of Civil Service's (DCS) Employee Health Service (EHS) practices and that of:

- Any health care professional authorized by EHS to enter information into your medical and/or nursing record.
- All EHS employees, staff and other medical personnel.
- All divisions and personnel of the Department of Civil Service.
- All medical service vendors who perform functions under contract for the Department of Civil Service.

If you have any questions about this Notice, please contact the EHS Administrator at (518) 233-3100. All correspondence directed to EHS should be sent to the following address:

Employee Health Service
New York State Department of Civil Service
55 Mohawk Street – Suite 201 Cohoes, New York 12047

Our Pledge Regarding Medical Information:

EHS understands that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the services you receive at all EHS nursing stations and medical clinics. We need this record to provide you with quality services and to comply with certain legal requirements. This notice applies to all of the records of your medical status and services maintained by EHS, whether generated by EHS personnel, by staff where you work who referred you to EHS, or by your personal doctor.

This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practice with respect to medical information about you;
- Follow the terms of the notice that is currently in effect;
- Maintain the privacy of your medical information. If any of your medical information is ever released without your permission, we will notify you and advise you of the risks.

How We May Use and Disclose Medical Information About You:

The following categories describe different ways that EHS uses and discloses medical information. For each category of uses and disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories:

- For Treatment. EHS may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, medical test assistants, paramedics, or other emergency medical personnel who are involved in taking care of you at your work site or at an EHS clinic location. For example, if you are diabetic, become ill while at work, and require transport to a hospital for treatment, the EHS nurse would tell the paramedics that you have diabetes so that this information could be passed along to the emergency room staff. We may also tell your designated contact person if you require transfer to a hospital.
- For Payment. We may use and disclose medical information about you so that the services you receive at EHS may be billed to and payment may be collected from the New York State department or agency where you are employed. For example, we may need to give the NYS agency where you are employed a listing of the services that you received from EHS so that your agency will pay us.

- For EHS Operations. We may use and disclose medical information about you for EHS operations. These uses and disclosures are necessary to run the Department and/or EHS. For example, when we schedule an appointment for you at one of our medical services contractors, we will provide them with information about you.
- Appointment Scheduling. We may use and disclose medical information to contact you concerning an appointment for services or in response to questions you may have asked regarding a specific program.
- Individuals Requesting Services for You or Involved in Payment for Your Services. We may release medical information about you to the individual in the Personnel Office at the New York State department or agency where you are employed. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. Before we use or disclose medical information for research, the project will have been approved through a stringent approval process. We will ask for your specific permission if the researcher will be collecting your name, address, or other information that reveals who you are.
- As Required by Law. We will disclose medical information about you when required to do so by federal, state or local law.
- To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- Military and Veterans. If you are a member of the armed forces or reserves, we may release medical information about you as required by military command authorities.
- Workers' Compensation. We may release medical information about you for workers' compensation or similar programs.
- Public Health Risks. We may provide medical information about you to prevent or control disease, injury or disability, such as to report reactions to medications.
- Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure.
- Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- Law Enforcement. We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct at the Department or associated with EHS; and
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Your Rights Regarding Medical Information About You:

You have the following rights regarding medical information we maintain about you:

- Right to Inspect and Copy. You have the right to inspect and copy medical information we maintain about you. For instructions on how to inspect and/or obtain a copy of your personal medical information, refer to the EHS web page at www.cs.ny.gov/ehs, ask the EHS Nurse in your building, or call the EHS Medical Records Clerk at (518) 233-3100. All requests must be in writing. If you request a copy of the information, we may charge a fee for the costs of retrieving, copying, and mailing your records. We may deny your request to inspect and/or obtain a copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The Department of Civil Service will assign a person to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- Right to an Accounting of Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing to the EHS Medical Records Clerk. You may ask for information about any disclosures made back six years from the date of your letter, but not before April 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list.
- Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for EHS. For instructions on how to request an amendment, ask the EHS Nurse in your building or call the EHS Medical Records Clerk at (518) 233-3100. All requests to amend or correct information in your health records must be made in writing. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us;
  - Is not part of the medical information kept by EHS;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.
- Right to Request Restriction. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who requested services for you or who is involved in the payment for your services, such as a friend, family member or a person at the NYS department or agency where you are employed. **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. For instructions on how to request restrictions, ask the EHS Nurse in your building or call the EHS Medical Records Clerk at (518) 233-3100. All requests to restrict or limit disclosure of your personal health information must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.
- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home or by mail. To request confidential communications, you must make your request in writing to the EHS Nurse in your building or EHS Medical Records Clerk. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- Right to a Paper Copy of This Notice. You have the right to receive a copy of this notice upon request. A paper copy can be obtained on the EHS web page www.cs.ny.gov/ehs, by writing to EHS at the address at the end of this Notice or calling the EHS Administrator at (518) 233-3100.

Other Uses of Medical Information

Other uses and disclosure of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

Access Limitation

Copyrighted psychological testing documents, including testing booklets and questions, test-scoring keys, and interpretive reports, that if released would result in disclosure of trade secrets or undermine the integrity and validity of test results, will not be released to you or your representative. These documents will only be released to a licensed psychologist able to interpret the information.

Changes to This Notice

EHS reserves the right to change this Notice and make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the waiting area of the EHS Medical Clinic and all EHS nursing stations. In addition, when you register at or request services at an EHS location, we will offer you a copy of the current notice
in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Department of Civil Service or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Department of Civil Service, contact the Department's HIPAA Privacy Officer's office at (518) 473-1841 to request a form. All complaints must be submitted in writing and should be filed within 180 days of when you learned of the problem. **You will not be penalized for filing a complaint.**

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE HEALTH SERVICE

Statement of Physical and Medical Requirements

Correction Officer & CO Trainee, Parole Officer & PO Trainee, & Institution Safety Officer

EHS PM-11 (3/2022)

NOTE: CANDIDATES ARE REQUIRED TO MEET THE PHYSICAL AND MEDICAL REQUIREMENTS STATED BELOW AND, IN THE ANNOUNCEMENT, AT THE TIME OF THE MEDICAL EXAMINATION, AT THE TIME OF APPOINTMENT, AND AT APPROPRIATE INTERVALS THEREAFTER

1. **Height and Weight** - Will not interfere with the candidate's ability to perform the essential functions of the position. All candidates will be evaluated for the ability to perform job-specific tasks.

2. **Speech** - Must be free of speech pathology which would interfere with the ability to communicate clearly.

3. **Vision** - Distant visual acuity should be correctable to better than, or equal to 20/30 (Snellen)in each eye; if correction is required, binocular visual acuity should be better than, or equal to 20/70 without correction. Binocular peripheral vision should not be less than 170 degrees.

4. **Color Vision** - Perception of color is deemed acceptable if the candidate correctly reads (9) or more of the first thirteen (13) plates of the 24-plate edition of the Ishihara Test. If the candidate's color perception is deemed unacceptable through the use of said test and he/she believe the results to be incorrect, such an individual may at his/her own expense take the Farnsworth-Munsell 100-Hue Test. (a) the test must be taken under the supervision of an ophthalmologist having the proper equipment and utilizing the standards established by the Municipal Police Training Council. (b) if the candidate takes and completes the Farnsworth-Munsell 100-Hue Test, the specialist shall certify in writing whether or not the candidate meets the required color perception standards. (c) both eyes should be examined together and scored as such. (d) if a candidate fails the initial test, he/she must, upon request, be immediately retested and the lower total error score used for purposes of qualification. A total error score of not more than 124 is deemed acceptable. (e) the use of any lens by a officer candidate in order to meet the color perception standard is not acceptable.

5. **Hearing** - The average hearing level (HL) for the 3 test frequencies of 500, 1000, and 2000 Hz will not exceed 25 dB in either ear, and no single hearing level will exceed 30 dB at any of these 3 test frequencies in either ear. Hearing loss at 3000 Hz will not exceed 40 dB HL in either ear. Use of hearing aids is permitted as long as they are self-contained and fit within (auricular) or behind or over (post-auricular) the ear. Candidates with hearing aids, at their own expense, must provide evidence from a licensed audiologist, using functional gain or real ear measurements, that their aid(s) meet the stipulated manufacturers standards. Recourse Testing: If the candidate's pure tone screening test is deemed unacceptable, such candidates may at his/her own expense have an audiological evaluation administered by a NYS licensed audiologist, including: 1. hearing sensitivity, 2. speech discrimination in quiet, 3. speech discrimination in noise. Testing should be performed in a sound-treated environment meeting the 1969 ANSI or any subsequent standard. The CID W-22-word lists should be presented at 50 dB HL via a calibrated speech audiometer through a single speaker stationed at 0 degrees azimuth with the candidate seated at approximately 1 meter (39 inches) from the speaker. Speech (hearing) discrimination testing in a background of broad-band noise should be conducted in the same sound field environment. Again, using a different version of one of the CID W-22 word lists presented at 50 dB HL, a competing noise should be simultaneously presented at 40 dB HL (S/N=+10) through the same speaker (0 degrees azimuth) as the test words or through a separate speaker located at 180 degrees azimuth. The minimal acceptable standard of speech (hearing) discrimination shall be a score no poorer than 90% in quiet and 70% in noise on two of the pre-recorded versions of the CID W-22-word lists. An open-test response format should be utilized with the candidate responding in writing.

6. **Cardiovascular** - Candidate must have a functional and therapeutic cardiac classification no greater than NYS Class IA. This determination must be made clinically or by cardiac stress test. Candidates with uncontrolled high blood pressure will be restricted pending remediation.

7. **Respiratory System** - The respiratory system must be free of chronically disabling conditions that would interfere with the candidate's ability to perform the essential functions of the position.

8. **Diabetes** - Candidates who are diabetic must provide evidence of satisfactory medical control. Candidates will be evaluated on a case-by-case assessment as to the control of diabetes and presence and severity of symptoms and complications.

9. **Neurological Health** - Candidates must be free of neurological disorders that would interfere with the candidate's ability to perform the essential functions of the position. Candidates with any type of epilepsy or seizure disorders must provide evidence of one-year seizure free history with or without drug control.

10. **Musculoskeletal Health** - Candidates must have no defects, deformities or disorders that will interfere with the candidate's ability to perform the essential functions of the position. The use of prostheses or braces is allowed as long as the candidate can perform the full range of duties of the position and no security risk is posed.

General Medical Statement

A. Candidates must be free of any medical condition, including drug abuse, alcohol abuse, and/or any psychiatric disorder* that would jeopardize the safety and health of inmates, parolees, the public, and/or other employees or would clearly interfere with the ability to perform the essential functions of the position.

B. Candidates may not have a medical problem that prevents them from working mandatory unscheduled overtime.

C. Candidates found to be abusing legal drugs or using illegal drugs will be disqualified.

D. **Cannabis use is not permitted for incumbents in these titles. Cannabis use will be tested for and may be a basis for disqualification for employment or may be a basis for removal from employment.**

* Candidates will be required to undergo a psychological evaluation scheduled and conducted through the Department of Corrections and Community Supervision.