

**REQUEST FOR AMBULANCE VOLUNTEER PHYSICAL EXAMINATION**

Part A – To be completed by the requesting officer and volunteer.

NAME OF AMBULANCE VOLUNTEER: \_\_\_\_\_

AMBULANCE CO.: \_\_\_\_\_ TOWN/VILLAGE: \_\_\_\_\_

SOCIAL SECURITY NO.: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

AMBULANCE VOLUNTEER'S ADDRESS: \_\_\_\_\_

PHONE NUMBER(S): \_\_\_\_\_ EMAIL: \_\_\_\_\_

EMPLOYER/EMPLOYER'S ADDRESS: \_\_\_\_\_

TYPE OF PHYSICAL:  CURRENT  NEW MEMBER  RE-EXAM

NAME OF REQUESTING OFFICER: \_\_\_\_\_

PHONE NUMBER(S): \_\_\_\_\_ EMAIL: \_\_\_\_\_

Part B – To be completed by the volunteer.

Volunteer Agreement (Please read and sign.)

As a volunteer for the Ambulance Co. in Allegany County, I do hereby give permission for the Allegany County Mutual Self-Insurance Plan to receive a copy of my physical exam and to release to the above requesting officer, the following results of physical examination, for the purpose of determining my physical ability to perform the duties of a volunteer ambulance worker.

Date: \_\_\_\_\_ Ambulance Volunteer Signature: \_\_\_\_\_

Part C – To be completed by the Workers' Compensation Office

**RESULTS OF PHYSICAL EXAMINATION**

EXAMINING PHYSICIAN: \_\_\_\_\_ DATE OF EXAMINATION: \_\_\_\_\_

- RECOMMENDATIONS
- a. No Restrictions – Full Activity
  - b. Minor Restrictions – Limited Activity
  - c. Major Restrictions – Very Limited Activity
  - d. Not physically suitable for active duty

DATE FORM MAILED TO REQUESTING OFFICER: \_\_\_\_\_ No. \_\_\_\_\_