



## Candidate Medical Exam Packet

Austin Fire Department Wellness Center  
517 S. Pleasant Valley Rd., Austin, TX  
(512) 974-0203 phone (512) 974-0222 fax

### Candidate Medical Exam Checklist

#### Blood work/urinalysis:

- Lab work must be completed by Aug. 31, 2012.
- You will use Clinical Pathology Laboratories (CPL) for your lab work. In the Austin area (map provided in this packet), report to your preferred Patient Service Center, provide your name and state clearly, "My order is in the computer."
- For CPL locations outside the Austin area, locate a Patient Service Center at: [www.cpllabs.com](http://www.cpllabs.com). When you arrive, call (512) 974-0203 and provide us with a fax number for that location. We will fax your lab authorization form to that location at that time. For locations outside the Austin area, YOU MAY ONLY HAVE LAB WORK DONE MONDAY-FRIDAY, 8:00 am- 11:30 am based on the Wellness Center's availability, not CPL's available hours.
- You must fast 12 hours prior to your lab work, drinking only water.

#### Medical Exam:

- **YOUR APPOINTMENT DATE/TIME IS:** \_\_\_\_\_.
- Location: AFD Wellness Center, 517 S. Pleasant Valley Rd. Map and directions are provided in this packet.
- Bring identification.
- Wear appropriate clothing and shoes for running on a treadmill. See attached treadmill protocol.
- If you wear contacts, bring a container to put them in- your vision may be tested with AND without your contacts.
- Men- shave your chests for ECG lead placement. Men and women- no body oils or lotions on your chest due to ECG lead placement.
- Women- have the "Annual Exam Results Release to AFD (Candidate)" form completed. Actual exams need to have been completed in the past 12 months.
- All- Complete ALL medical history forms (attached in this packet) BEFORE arriving at the Wellness Center. Bring your shot records with you to the exam.
- Fax all medical records from significant medical events/conditions to the Wellness Center at (512) 974-0222 prior to your medical exam. This includes any records involving past surgeries, hospitalizations, or medical treatment for significant conditions. Significant medical conditions include, but are not limited to: asthma, cardiac conditions, orthopedic injuries, psychiatric conditions, back or neck injuries, and heat stress injuries.
- Based on your medical exam, the Wellness Physician may require follow up information about you from a specialist. Any requested specialist documentation must be completed and returned by Nov. 2, 2012. This documentation should be faxed to (512) 974-0222 to the Wellness Center. If you fail to provide the required documentation by the deadline you will be disqualified from the hiring process.

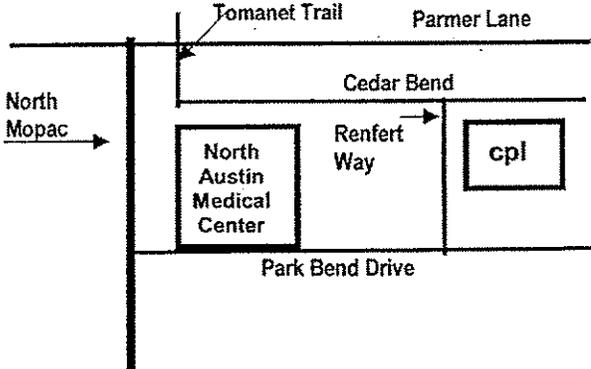
#### Chest X-Ray:

- Applicants will be provided with a chest x-ray authorization form for a Promed Medical Care Center location when you take your written psychological examination. The chest x-ray must be completed by Aug. 31, 2012.
- Location: Locations and hours of operation are listed on the chest x-ray authorization form. All locations are in the Austin area.

The Austin metro Patient Service Centers are staffed by trained and experienced personnel who receive the patients referred by physicians and collect the required specimens.

**North Austin**

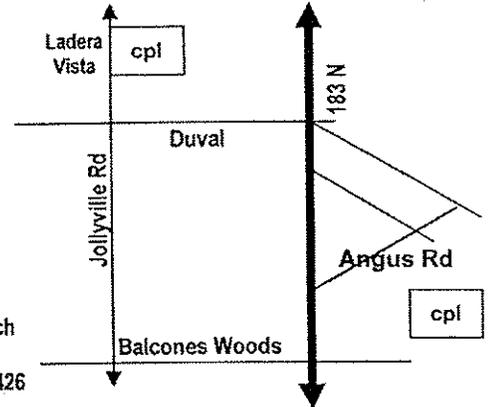
Medical Oaks Pavilion  
12201 Renfert Way, Ste. 330 7:00 AM – 5:00 PM, Open lunch  
Austin, Texas 78758 512-835-4093 Fax 512-835-0820



**Northwest Austin**

Ladera Park  
11673 Jollyville Rd., # 106  
Austin, Texas 78758  
7:00 AM – 5:00 PM  
512-257-3547  
Fax 512-250-5395

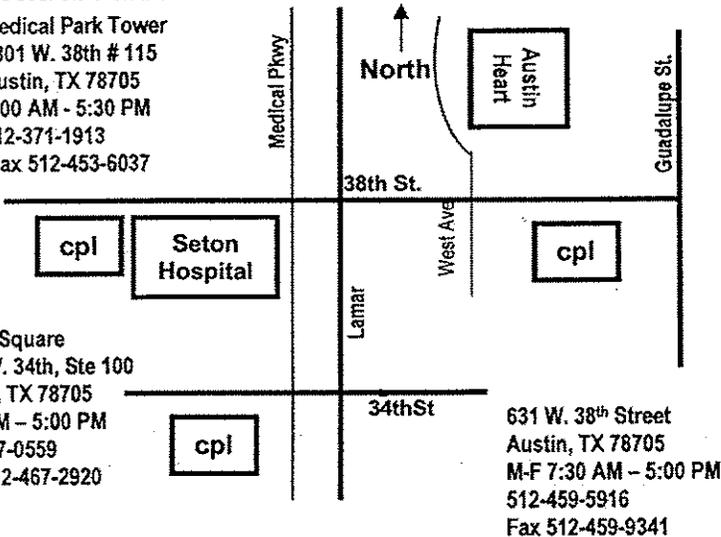
Twelve Oaks Medical Center  
11645 Angus Rd. Ste. B6  
Austin, Texas 78759  
7:00 AM – 5:00 PM, Open lunch  
Sat: 8:00 – Noon  
512-345-8819 Fax 512-418-1426



**Central Austin**

Medical Park Tower  
1301 W. 38th # 115  
Austin, TX 78705  
7:00 AM - 5:30 PM  
512-371-1913  
Fax 512-453-6037

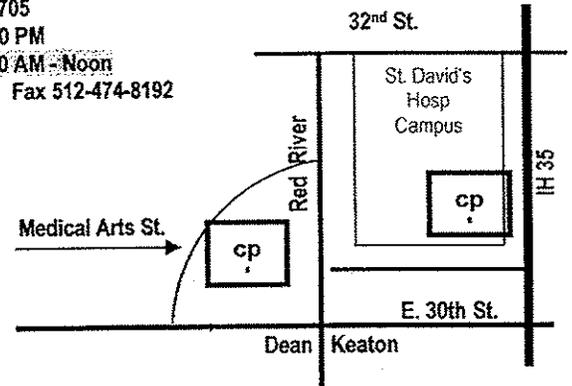
Medical Arts Square  
1301 W. 34th, Ste 100  
Austin, TX 78705  
7:00 AM – 5:00 PM  
512-467-0559  
512-467-2920



**Central Austin**

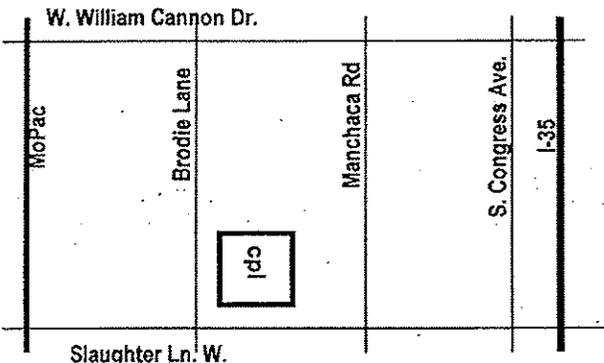
St. David's Hospital Campus  
3000 IH-35, Suite 660  
Austin, TX 78705  
7:00 AM – 5:00 PM  
512-391-0803 Fax 512-391-1626

Medical Arts Square  
2911 Medical Arts St. # 4  
Austin, TX 78705  
7:00 AM – 5:00 PM  
Saturday: 8:00 AM - Noon  
512-474-7566 Fax 512-474-8192



**South Austin**

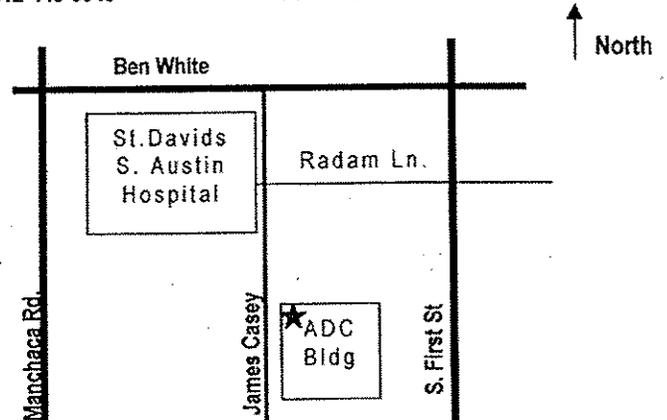
Brodie Lane  
9701 Brodie Lane, Suite 103 7:00 AM – 5:00 PM, Open Lunch  
Austin, TX 78748 512-291-4350 / 512-291-4399  
Fax 512-291-1756



**South Austin**

4315 James Casey  
Austin, TX 78745  
512-445-0045

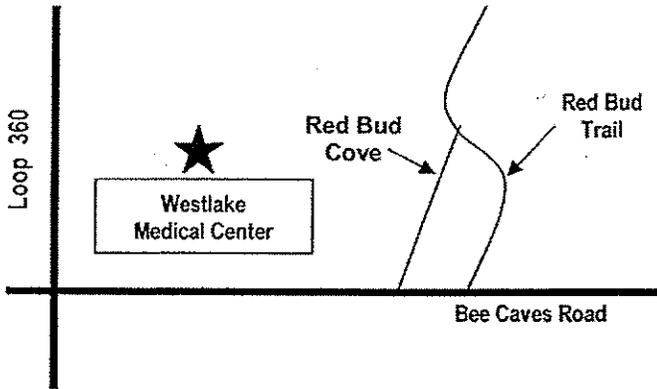
7:00 AM – 5:00 PM, Open Lunch  
Saturday: 8:00 AM - Noon  
Fax 512-326-1051



CPL is located inside the ADC Bldg. Entering through the front door, CPL is the first door on the left.

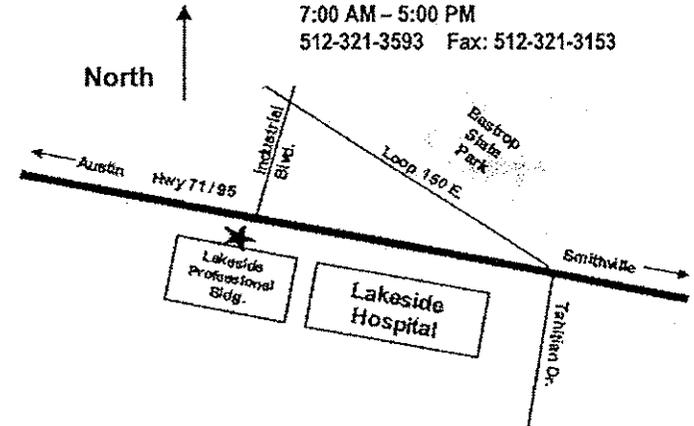
**Southwest Austin**

Westlake Medical Center  
5656 Bee Caves Rd., Ste K-101  
Westlake Hills, TX (Austin)  
7:00 AM – 5:00 PM, Open Lunch  
512-328-2462 Fax 512-328-2478



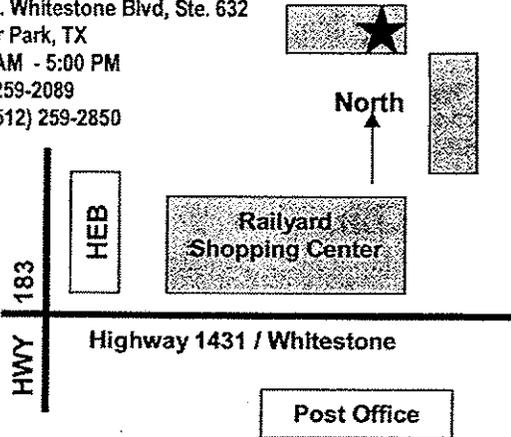
**Bastrop**

Lakeside Professional Bldg.  
3101 Hwy 71 East, Suite 206  
Bastrop, TX 78602  
7:00 AM – 5:00 PM  
512-321-3593 Fax: 512-321-3153



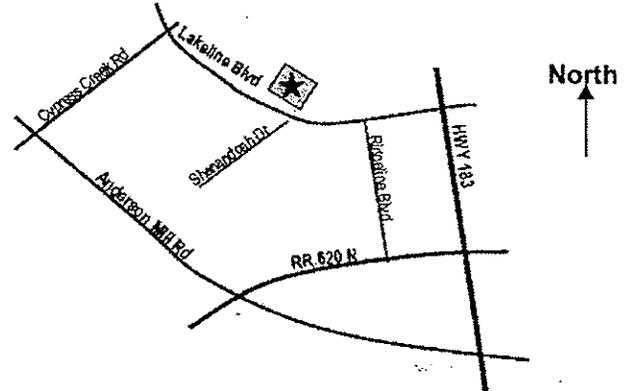
**Cedar Park – Whitestone (Hwy 1431)**

CPL Cedar Park  
601 E. Whitestone Blvd, Ste. 632  
Cedar Park, TX  
7:00 AM - 5:00 PM  
512- 259-2089  
Fax (512) 259-2850



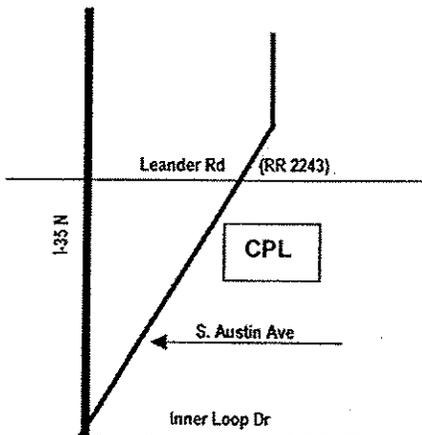
**Cedar Park - Lakeline Blvd.**

CPL Cedar Park  
2500 S. Lakeline Blvd, Suite 203  
Cedar Park, TX 78613  
7:00 AM - 5:00 PM  
512- 257-3180 Fax (512) 258-1154



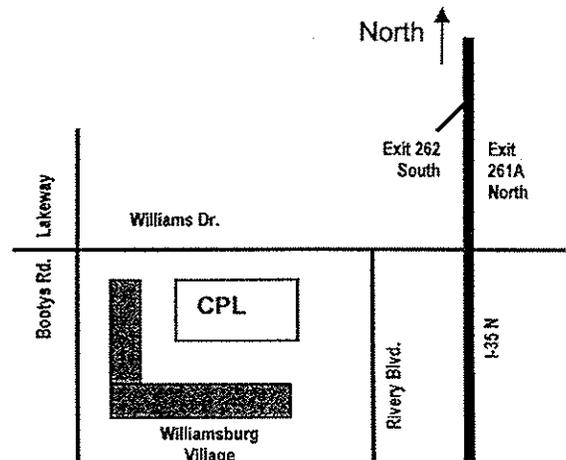
**Georgetown**

CPL Georgetown –S. Austin Ave.  
3201 S. Austin Ave, Ste 120,  
Georgetown, TX 78628  
7:00 AM – 5:00 PM, Open Lunch  
512-763-4590 Fax 512-763-4595



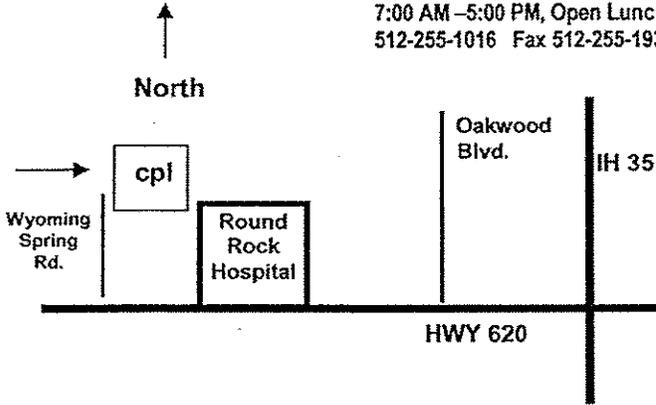
**Georgetown**

CPL Georgetown -Williamsburg Village  
3010 Williams Drive, Suite 222,  
Georgetown, TX 78628  
7:00 AM – 5:00 PM, Open Lunch  
512-930-5044 Fax 512-930-5166



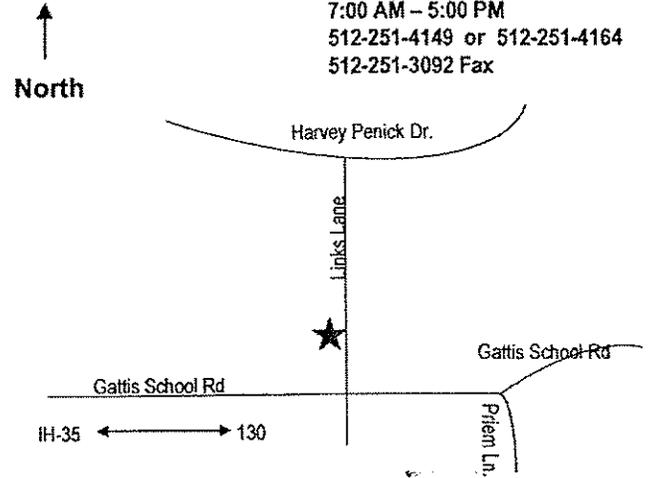
**Round Rock**

Wyoming Springs Medical Building  
7200 Wyoming Springs Rd, # 100  
Round Rock, TX 78681  
7:00 AM - 5:00 PM, Open Lunch  
512-255-1016 Fax 512-255-1932



**Round Rock**

Forest Creek PSC  
4112 Links Lane, Suite 100  
Round Rock, TX 78664  
7:00 AM - 5:00 PM  
512-251-4149 or 512-251-4164  
512-251-3092 Fax



# Candidate Medical Exam Packet

Map of 517 S Pleasant Valley Rd, Austin, Texas | MapQuest

Page 1 of 1

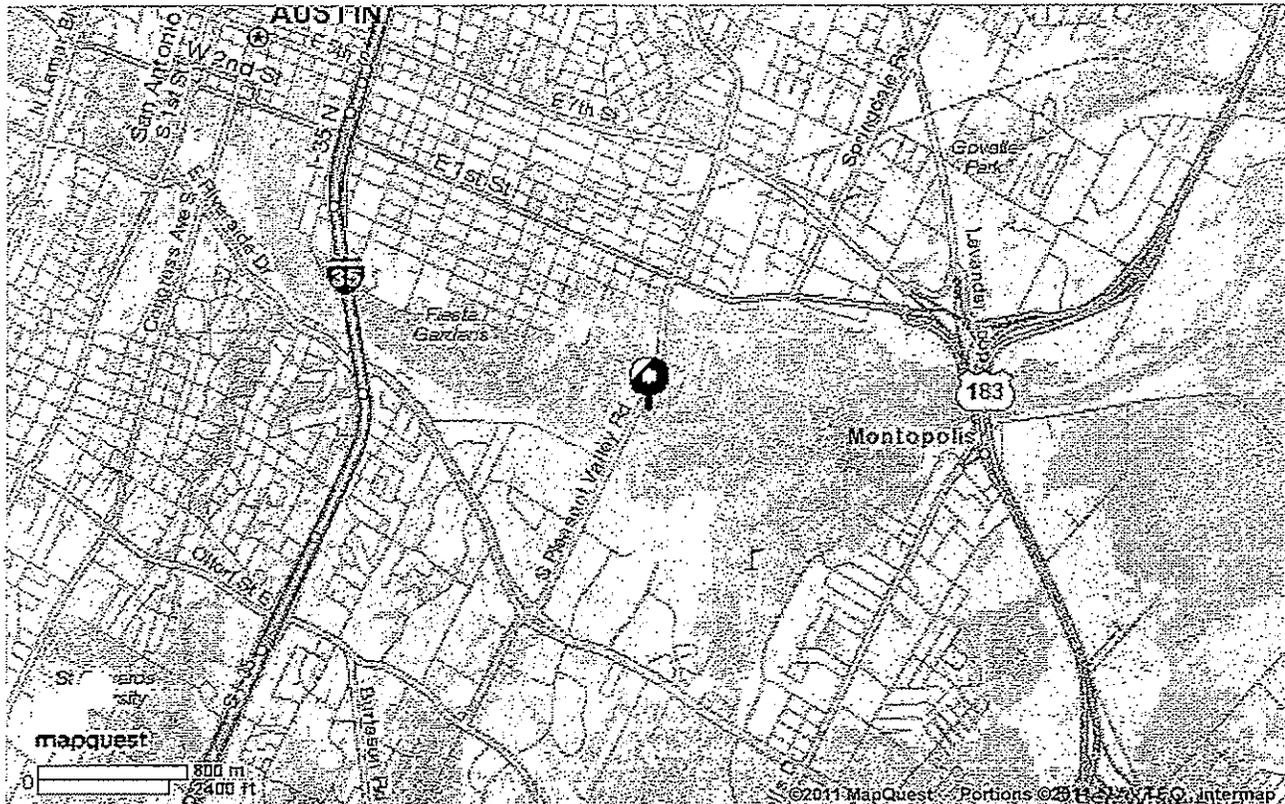
## mapquest

Map of:

517 S Pleasant Valley Rd  
Austin, TX 78741-1902

### Notes

From I-35, exit Riverside. Go east.  
Take a left on Pleasant Valley Road.  
At the 3rd light, take a right into Krieg Softball Complex.  
We are the main building on the left. The entrance faces away from Pleasant Valley.  
If you get to the Longhorn dam, you've gone too far.



All rights reserved. Use subject to License/Copyright

Directions and maps are informational only. We make no warranties on the accuracy of their content, road conditions or route usability or expeditiousness. You assume all risk of use. MapQuest and its suppliers shall not be liable to you for any loss or delay resulting from your use of MapQuest. Your use of MapQuest means you agree to our [Terms of Use](#)



# Austin Fire Department Wellness Center

517 S. Pleasant Valley Rd., Austin Tx 78741 (512)974-0200phone (512)974-0222fax



## AFD Candidate Exam Process and Medical Questionnaire

<b>Name:</b>	<b>Date of Birth:</b>	<b>Age:</b>	<b>Candidate ID:</b>
<b>Street Address/City/State/Zip:</b>		<b>Best Phone Contact Number:</b>	
<b>ALLERGIES (Medications, food, environmental):</b>			
<b>List all CURRENT Medications:</b>	<b>Medical Conditions:</b>	<b>Healthcare Providers:</b>	
<b>List any hospitalizations, ER visits, medical procedures and/or doctor visits (Including Work-Related Injuries/Exposures) in past year:</b>			

### PERSONAL HEALTH HISTORY

Condition	Never	Past	Present	Condition	Never	Past	Present
1. Skin rash / Skin disease				28. Respiratory Disease			
2. Weight gain / loss > 10 lbs				29. Asthma / Wheezing			
3. Diabetes				30. Bronchitis			
4. Cancer				31. Pneumonia			
5. Psychiatric Issue / Disorder				32. Emphysema			
6. Claustrophobia				33. Silicosis			
7. Fertility problems in self or partner				34. Collapsed Lung			
8. Stroke or Paralysis				35. Lung Cancer			
9. Epilepsy or Seizure Disorder				36. Chest Injury / Surgery			
10. Black Out Spells or Fainting				37. Shortness of Breath			
11. Recurrent Headaches				38. Coughing			
12. Head Injury				39. Kidney Problems			
13. Neurological Disease / Disorder				40. Urinary Problems			
14. Eye Problems / Surgeries				41. Hernia or Rupture			
15. Wear Glasses or Contacts				42. Gastrointestinal Problems			
16. Ear Problems / Surgeries				43. Heartburn / Indigestion			
17. Difficulty Hearing				44. Back Pain / Problems / Injury			
18. Nose, Throat, Sinus problems				45. Muscle Weakness			
19. Trouble Smelling Odors				46. Joint Pain			
20. Chest Pain				47. Arthritis			
21. Heart Attack				48. Orthopedic Surgeries			
22. Heart Arrhythmia / Palpitations				49. Broken bones or fractures			
23. Heart Failure				50. Difficulty moving around			
24. High Blood Pressure				51. TB Exposure / Positive Skin Test			
25. High Cholesterol				52. Hepatitis A / B / C / D			
26. Heart Disease				53. Other operations/surgeries/medical conditions			
27. Cardiac Surgeries or Procedures							

### WELLNESS CENTER REVIEW/COMMENTS:

Denies other medical conditions, hospitalizations, and/or operations

**PERSONAL HABITS**

(Complete the table regarding your personal habits)

Habits:	Never	Occasionally	Daily	Weekly	Monthly
Exercise/Sports (type):					
Hobbies (type):					
Chewing Tobacco:					
Smoking: _____ cigarettes/cigars per					
Alcohol (type): _____ drink(s) per					
Caffeine Intake (coffee/tea/cokes): _____ per					

**WORK HEALTH HISTORY**

	Yes	No	Which Job	When (Dates)
Have you ever worked in a dusty trade such as mining, quarry, foundry work, sandblasting, or a chemical industry?				
Have you ever worked with asbestos?				
Have you ever worked with or been treated with x-ray, radioactive material or laser?				
Have you ever had any serious ill effects from the kind of work you have done?				
Have you ever filed for Worker’s Compensation due to an injury or accident?				

**NOTICE TO CANDIDATES:**

You are required to complete a medical examination at the Wellness Center as part of the Austin Fire Department’s Hiring Process. On this visit, you will be directed through the following tests: Vision, Hearing, Cardiac Treadmill, Pulmonary Function Testing (Spirometry), and Physical Exam, including review of lab results with the physician.

**A staff member will be directing you through each of these tests; DO NOT ask any staff member if you “passed” or “failed” the test. The physician will make a recommendation to the Hiring Coordinator; you will receive your pass/fail results SOLELY FROM THE HIRING PROCESS COORDINATOR.** You will receive a written summary of the medical evaluation, including a copy of your lab results.

**The physician may require that you complete additional testing with a Primary Care or Specialist Physician in order to make a recommendation to the Hiring Coordinator; results of any additional testing must be delivered to the Wellness Center as directed by the physician and/or Hiring Coordinator. Failure to have results delivered by the deadline may result in disqualification from the process.**

As part of your Hiring Process Medical Exam, you will be required to participate in diagnostic procedures (Spirometry, Hearing, Vision, and Cardiac Treadmill Testing) to assess your physical work capacity, which may require increasingly strenuous effort. The Cardiac Stress Test is performed on a treadmill and is comprised of increasingly strenuous (speed/incline) walking/jogging on a treadmill while being monitored by EKG apparatus and a trained technician. A physician will be onsite in the clinic at all time during your test. You will exercise to a predetermined stopping point, or to the point of fatigue, breathlessness, chest pain, and/or any other sign or symptom that would indicate the need to stop the exercise, whichever is sooner. The risks associated with performing a Stress Test include: breathing difficulties, chest pain, irregular heartbeat, changes in blood pressure, fainting, heart attack, stroke, and death. You will be required to sign a consent form specific to the Cardiac Stress Test.

**“I certify that the answers on this form are true and complete; and I agree to provide accurate health and medical information to the best of my knowledge to the Wellness Center. I understand the risks associated with the testing and consent to perform the tests as directed by the Wellness Center staff.”**

Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>NAME:</b>	<b>ID:</b>	<b>AGE:</b>	<b>DOB:</b>	<b>DATE:</b>
--------------	------------	-------------	-------------	--------------

**Respiratory Questionnaire  
Page 1**

<b>HT:</b>	<b>WT:</b>	<b>Phone #:</b>	Best time to contact you at this number:
------------	------------	-----------------	--

<b>Check the type of respirator you will use:</b> <input type="checkbox"/> N, R, or P disposable respirator (filter-mask, non-cartridge type only) <input type="checkbox"/> Other type (half- or full- facepiece type, powered-air purifying, supplied-air, or SCBA)	<b>Have you worn a respirator before?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes. What type? _____ Any problems? _____
--	--

<b>Please answer the following questions:</b>	<b>Comments:</b>
1. <b>Do you currently smoke tobacco, or have you smoked tobacco in the last month?</b>	NO YES: PksPerDay ___ x ___ yrs
2. <b>Have you ever had any of the following conditions?</b> (Check and explain if "yes") <input type="checkbox"/> Seizures <input type="checkbox"/> Diabetes <input type="checkbox"/> Claustrophobia <input type="checkbox"/> Trouble smelling odors <input type="checkbox"/> Allergic reactions that interfere with your breathing	<input type="checkbox"/> NO <input type="checkbox"/> YES
3. <b>Have you ever had any of the following pulmonary problems?</b> (Check and explain if "yes") <input type="checkbox"/> Asbestosis <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Silicosis <input type="checkbox"/> Pneumothorax(collapsed lung) <input type="checkbox"/> Lung cancer <input type="checkbox"/> Broken ribs <input type="checkbox"/> Chest Injury or Surgery (explain) <input type="checkbox"/> Other (explain)	<input type="checkbox"/> NO <input type="checkbox"/> YES
4. <b>Do you currently have any of the following pulmonary symptoms?</b> (Check and explain if "yes") <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Shortness of breath when walking fast on level ground or when walking up a slight hill or incline <input type="checkbox"/> Shortness of breath when walking at ordinary pace on level ground <input type="checkbox"/> Have to stop for breath when walking at own pace on level ground <input type="checkbox"/> Shortness of breath when washing or dressing yourself <input type="checkbox"/> Shortness of breath that interferes with your job <input type="checkbox"/> Coughing that produces phlegm <input type="checkbox"/> Coughing that occurs mostly when you are lying down <input type="checkbox"/> Coughing up blood in the last month <input type="checkbox"/> Wheezing <input type="checkbox"/> Wheezing that interferes with your job <input type="checkbox"/> Chest pain when you breathe deeply <input type="checkbox"/> Other (explain)	<input type="checkbox"/> NO <input type="checkbox"/> YES
5. <b>Have you ever had any of the following cardiovascular symptoms?</b> (Check and explain "yes") <input type="checkbox"/> Heart attack <input type="checkbox"/> Stroke <input type="checkbox"/> Angina <input type="checkbox"/> Heart Failure <input type="checkbox"/> Swelling in legs or feet <input type="checkbox"/> Heart Arrhythmia <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Other (explain)	<input type="checkbox"/> NO <input type="checkbox"/> YES
6. <b>Have you ever had any of the following cardiovascular symptoms?</b> (Check and explain if "yes") <input type="checkbox"/> Frequent pain or tightness in your chest <input type="checkbox"/> Chest pain/tightness during physical activity or that interferes with your job <input type="checkbox"/> In past two years, have you noticed your heart skipping or missing a beat? <input type="checkbox"/> Heartburn or indigestion not related to eating <input type="checkbox"/> Other (explain)	<input type="checkbox"/> NO <input type="checkbox"/> YES
7. <b>Do you currently take medication for:</b> <input type="checkbox"/> Breathing or lung problems <input type="checkbox"/> Heart problems <input type="checkbox"/> Blood pressure <input type="checkbox"/> Seizures	<input type="checkbox"/> NO <input type="checkbox"/> YES

<b>NAME:</b>	<b>ID:</b>	<b>AGE:</b>	<b>DOB:</b>	<b>DATE:</b>
--------------	------------	-------------	-------------	--------------

**Respiratory Questionnaire**  
**Page 2**

8. Would you like to talk to the health care professional who will review this questionnaire?	<input type="checkbox"/> NO <input type="checkbox"/> YES
9. Have you ever lost vision in either eye (temporarily or permanently)?	<input type="checkbox"/> NO <input type="checkbox"/> YES
10. Do you currently have any vision problems? (Explain "yes") <input type="checkbox"/> Wear contact lenses <input type="checkbox"/> Wear glasses <input type="checkbox"/> Color blind <input type="checkbox"/> Other	<input type="checkbox"/> NO <input type="checkbox"/> YES
11. Have you ever had an injury to your ears, including a broken ear drum?	<input type="checkbox"/> NO <input type="checkbox"/> YES
12. Do you currently have any of the following hearing problems? (Explain "yes") <input type="checkbox"/> Difficulty hearing <input type="checkbox"/> Wear a hearing aid <input type="checkbox"/> Other	<input type="checkbox"/> NO <input type="checkbox"/> YES
13. Have you ever had a back injury?	<input type="checkbox"/> NO <input type="checkbox"/> YES
14. Do you currently have any of the following musculoskeletal problems: (Explain "yes") <input type="checkbox"/> Weakness in any of your arms, hands, legs, or feet <input type="checkbox"/> Back pain <input type="checkbox"/> Difficulty fully moving your arms or legs <input type="checkbox"/> Difficulty bending your knees <input type="checkbox"/> Pain or stiffness when you lean forward or backward at the waist <input type="checkbox"/> Difficulty fully moving your head up or down or side to side <input type="checkbox"/> Difficulty squatting to the ground <input type="checkbox"/> Climbing flight of stairs or ladder <input type="checkbox"/> Any other muscle or skeletal problem	<input type="checkbox"/> NO <input type="checkbox"/> YES

Candidate Medical Exam Packet

During the medical exam, you will be required to pass a treadmill stress test. The following treadmill protocol will be used.

Treadmill test for Fire Cadets

<b>Stage</b>	<b>Time (minutes)</b>	<b>Speed (mph)</b>	<b>Incline (% Grade)</b>
<i>Warm – up</i>	0:00 – 2:59	3.0	0
I	3:00 – 3:59	4.5	0
II	4:00 – 4:59	4.5	2
III	5:00 – 5:59	5.0	2
IV	6:00 – 6:59	5.0	4
V	7:00 – 7:59	5.5	4
VI	8:00 – 8:59	5.5	6
VII *	9:00 – 10:59	6.0	6

The warm-up stage lasts 3 minutes. Stages I through VI last one minute. Stage VII lasts one minute and 59 seconds. The test will terminate at 11 minutes.



# Austin Fire Department Wellness Center

## Dr. Paul Parrish



517 S. Pleasant Valley Rd., Austin Tx 78741 (512)974-0200phone (512)974-0222fax

### ANNUAL EXAM RESULTS RELEASE TO AFD (Candidate)

I, \_\_\_\_\_, authorize \_\_\_\_\_  
 (Candidate name) (Healthcare Provider name)

to complete the information below. I also authorize its release and transmission to me and the Austin Fire Department Wellness Center (Dr. Paul Parrish) for the purpose of inclusion in the Hiring Process medical exam. I authorize that this letter may be mailed or faxed to the Wellness Center, using the address/number listed on this letterhead.

\_\_\_\_\_  
 (Signature) (Date)

**Healthcare Provider Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Exam Date:** \_\_\_\_\_

	Not Performed	Normal	Abnormal (please explain)
Breast Exam			
Pelvic Exam			
Pap Smear			

\_\_\_\_\_  
 (Healthcare Provider Signature) (Date)



# Austin Fire Department Wellness Center

517 S. Pleasant Valley Rd., Austin TX 78741 (512)974-0200phone (512)974-0222fax



Dear Candidate,

The Austin Fire Department provides a comprehensive infection control program that includes a focus on preventive immunizations and testing, as well as an exposure follow-up program. The Center for Disease Control and Prevention recommends the following immunizations for health care providers:

- Tetanus-diphtheria (Td) or Tetanus-diphtheria-acellular pertussis (Tdap)
- Hepatitis B (including a confirmatory antibody test)
- MMR (Measles Mumps Rubella)
- Varicella (Chicken pox)
- Influenza
- Hepatitis A
- PPD (TB) Skin Test (tuberculosis)

While none of these immunizations or tests is required for employment with the Austin Fire Department, several of them ARE required by the state in order to begin the clinical component of the Fire Academy (which includes training at area hospitals). These required immunizations are: Hepatitis B, MMR, TB, and Varicella.

In order to assist in evaluating your level of protection prior to commencing field activities, as well as providing access to such documentation in the event of an occupational exposure, mail a copy of your immunization records to the Wellness Center as soon as possible and no later than your scheduled medical exam. Use the attached "Candidate Immunization Record" to document your immunization history, and provide any supporting documentation (previous shot records, etc).

Most of the above listed immunizations are offered during the Academy (except Varicella). If you do not have these immunizations currently you do not need to get them before the Academy. If you wish to decline any or all of the vaccines (except those required for the clinical component of the Fire Academy) you will be required to sign a declination form. If you have any questions, you may contact the department's Infection Control Officer at 978-0030.

Wellness Staff  
517 S. Pleasant Valley Rd.  
(512) 974-0200 (512) 974-0203  
(512) 974-0222 fax

## CANDIDATE IMMUNIZATION RECORD

NAME \_\_\_\_\_ ID # \_\_\_\_\_

ADDRESS (street, city, state, zip) \_\_\_\_\_

BEST CONTACT NUMBER \_\_\_\_\_

Please complete the following table, and attach supporting documentation (previous shot records, lab results, etc.), and return to: AFD Wellness Center, 517 S. Pleasant Valley Road, Austin, Texas 78741.

IMMUNIZATION/ VACCINE	Abbrev.	Completed (date)	Records Attached (Yes/No)	Don't Know/ Don't Remember/ Comments
Measles, Mumps, Rubella (Childhood Vaccine)	MMR			
Measles, Mumps, Rubella (Adult Booster)*	MMR			
Hepatitis A- 1 <sup>st</sup> shot	HAV #1			
Hepatitis A- 2 <sup>nd</sup> shot	HAV #2			
Hepatitis B- 1 <sup>st</sup> shot*	HBV #1			
Hepatitis B- 2 <sup>nd</sup> shot*	HBV #2			
Hepatitis B- 3 <sup>rd</sup> shot*	HBV #3			
Hepatitis B titer/ antibody test	HBVAB			
Diphtheria- Pertussis- Tetanus	DPT			
Tetanus-diphtheria booster OR Tetanus- diphtheria- acellular pertussis booster	Td or Tdap			
Influenza	Flu			
TB Skin Test* (record results in MM in the "completed" column)**	TB or PPD			
Have you ever had chickenpox*? NO YES (date: _____)				
Have you had the varicella (chickenpox) vaccine*? NO YES (date: _____)				

\*The MMR booster, Hepatitis B series, TB Skin Test and Varicella (past disease, positive titer, or vaccination) will be required for the clinical component of the Fire Academy. These vaccines, except Varicella, will be provided to you at no cost if you are accepted into the Academy.

\*\*If a previous positive skin test is documented, provide documentations of date of last chest x-ray and completion of prophylaxis medication therapy (if applicable).