

Name:		UFID #:		Date of Birth:	
Height:		Weight:		Age:	
Position (Title):			Position #:		
Supervisor:			Department:		
Address:			Work Telephone Number:		
Do you have exposure to Class I type pesticides? (if Yes please describe)					
Do have any exposure to anti-cholinesterase type pesticides? (if Yes please describe)					
Have you had or do you now have any of the following:		Yes	Within the Last Year?	No	
1. Lung disease					
2. Persistent cough					
3. Shortness of breath					
4. History of fainting or seizures					
5. Heart Trouble					
6. Frequent pain / tightness in chest					
7. Heartburn/indigestion not related to eating					
8. High blood pressure					
9. Diabetes					
10. Trouble concentrating or remembering					
11. Heat exhaustion or heat stroke					
12. Ruptured ear drum					
13. Defective vision					
14. Defective hearing					
15. Other conditions that might interfere with respirator use or result in limited work ability					
16. Are you taking any medications (prescription or over-the-counter) If Yes, LIST:					
17. Do you currently smoke? If Yes, how many do you smoke per day?					
18. Have you had a significant medical or surgical problem since your last evaluation?					
Please Explain Yes Answers:					
Employee's Signature:				Date:	
Physician Use Only					
<input type="checkbox"/> No Restriction on Pesticide Use			<input type="checkbox"/> Further Evaluation Needed		
Physician's Review Signature:				Date:	