PRE-EMPLOYMENT PHYSICAL//DRUG TEST AUTHORIZATION

Procedures for complying with Williamson County's Post-Offer, Pre-Employment Physical and/or Drug Test Requirement:

Prospective employees in certain positions must pass a post-offer, pre-employment physical exam and/or drug test performed at one of the examination or testing centers designated by the County. See the list of testing sites below:

Family Medicine
3008 Dawn Drive, Suite 201, Georgetown, TX 78628 (512) 863-4596.
Employee to call for appointment.

On-Site Services Testing Center
8711 Burnet Road, Suite A-6, Austin, TX 78757 (512) 407-8111.
Hours: 8am-5pm (Mon-Fri) no appointment necessary

Family Medical Center of Georgetown
908 Rockmoor, Georgetown, TX 78628 (512) 868-0901.
Appointments requested to reduce waiting time.

Please check the exam(s) and/or test required for this applicant:

_____ **Regular Physical Exam and Drug Test (Family Medicine)**

_____ **Drug Test Only (Family Medical Center or On-Site Services)**

_____ **DOT Physical and Drug Test (Family Medical Center)**

Department Contact Person: Please complete this form and have the applicant present it upon arrival at the chosen testing center. Applicants should be made aware that if drug testing is required, a urine test will be administered and the applicant will need to be prepared to submit a urine specimen.

Departments: a copy of this form along with the employee's Drug Policy Acknowledgement Form will need to be sent to Human Resources by *e-mail* **wilco_hr@wilco.org** or by *fax* **(512) 943-1535**.

Doctors and testers do **not** need to return this form to the HR Department after tests & exams.

PROPOSED HIRE DATE:	**APPLICANT: Last Name, First Name Middle**
HIRING DEPT:	**JOB TITLE:**
APPLICANT PHONE NUMBER:	**APPLICANT ADDRESS:**

AUTHORIZED SIGNATURE REQUIRED: _____

Confidential Record
for Applicant &
Medical Provider

Department:_____

Job Title:_____

WILLIAMSON COUNTY
PHYSICAL EXAMINATION FORM
(To be completed by applicant)

Name:_____
Last First Middle Initial

Address:_____
Street City State Zip Code

Date of Birth:_____ **Social Security Number:**_____

Have you ever had or do you have any of the following problems?

	No	Yes		No	Yes
1. Severe Headaches	☐	☐	16. Stomach Problems	☐	☐
2. Loss of Consciousness	☐	☐	17. Black/Bloody Bowel Movements	☐	☐
3. Epilepsy	☐	☐	18. Hernia	☐	☐
4. Dizziness (Fainting Spells)	☐	☐	19. Kidney Problems	☐	☐
5. Nervous Disorders	☐	☐	20. Arthritis	☐	☐
6. Visual Problems	☐	☐	21. Back Pain or Injury	☐	☐
7. Hearing Problems	☐	☐	22. Joint Pains or Injury	☐	☐
8. Shortness of Breath	☐	☐	23. Broken Bones	☐	☐
9. Chronic Cough	☐	☐	24. Allergies	☐	☐
10. Emphysema	☐	☐	25. Diabetes	☐	☐
11. Asthma	☐	☐	26. Tumor	☐	☐
12. High Blood Pressure	☐	☐	27. Hepatitis	☐	☐
13. Chest Pain	☐	☐	28. Tuberculosis	☐	☐
14. Heart Problems	☐	☐	29. Alcohol Problems	☐	☐
15. Skin Problems	☐	☐	30. Drug Problems	☐	☐

Explain all "Yes" answers:

_____

_____

_____

Are you currently under a doctor's care? ☐ No ☐ Yes **For what problem?**_____

_____
Name of Doctor Address Phone Number

Do you smoke? ☐ No ☐ Yes How much?_____ Type:_____

Are you taking medication? ☐ No ☐ Yes Explain:_____

Have you ever had surgery? ☐ No ☐ Yes Explain:_____

_____

I hereby certify that all of the above answers are true to the best of my knowledge. I authorize the release of this medical record to my employer or prospective employer.

_____ _____
Applicant's Signature **Date**

(To be completed by medical examiner)

Applicant's Name:_____

General appearance & development: Good_____Fair_____Poor_____

Vision: Distance: Right 20/_____Left 20/_____
☐ Without corrective lenses
☐ With corrective lenses, if worn
Evidences of diseases or injury: Right_____ Left_____

Hearing: Right ear_____Left ear_____

Disease or injury_____

Thorax: Heart_____

Blood Pressure: Systolic _____Diastolic_____

Lungs_____

Abdomen: Scars_____Abnormal masses_____Tenderness_____

Hernia: ☐ No ☐ Yes If so, where?_____Is truss worn?_____

Reflexes: Rhomberg_____

Pupillary_____Light: R_____L_____

Knee jerks:
Right: Normal_____Increased_____Absent_____
Left: Normal_____Increased_____Absent_____
Remarks:_____

Extremities: Upper_____Lower_____Spine_____

Name:_____ Department:_____

Job Title:_____

WILLIAMSON COUNTY
RESULT OF PHYSICAL EXAMINATION

Based upon my examination of this individual:

___ The above individual is physically able to perform the essential functions of the position as described.

___ The above individual is **NOT** able to perform the essential functions of the position as described.

_____

Name of medical examiner **Address** **Phone Number**

_____ _____

Signature **Date**

Return this page to Williamson County Human Resources department. (no cover sheet required)
Fax line: (512) 943-1535
Email: **wilco_hr@wilco.org**