



Florida Department of Law Enforcement

PATIENT INFORMATION

Incorporated by Reference in Rule 11B-27.002(1)(d), F.A.C.



CJSTC 75A

- 1. Applicant's Name: _____
Last First MI
- 2. Applicant's Address: _____
Street, Apt. or Post Office Box Number City State Zip Code
- 3. Last Four Digits of Social Security Number: _____ Phone: _____ Date of Birth: _____
(In accordance with the Federal Privacy Act of 1974, disclosure is voluntary)
- 4. Hiring Agency: _____ 5. Position Applied For: _____

TO BE COMPLETED BY THE EXAMINING PHYSICIAN

Please note the presence of eyeglasses, contact lenses, hearing aids, or devices such as braces, supports, canes, crutches, or prostheses.

- 1. Gender: _____ 2. Height (in inches): _____ 3. Weight (pounds): _____ 4. Blood Pressure: _____
- 5. Resting Pulse: _____ (please note any irregularity) 6. Oral Temperature: _____
- 7. Resting Respiratory Rate: _____ 8. Corrected Visual Acuity: Right Eye: _____ Left Eye: _____
- 9. Physical Examination. Please check Normal or Abnormal after each entry and make comments at the bottom of the form.

	Normal	Abnormal
Color Perception	<input type="checkbox"/>	<input type="checkbox"/>
Estimated Field of Vision	<input type="checkbox"/>	<input type="checkbox"/>
Estimated Auditory Acuity	<input type="checkbox"/>	<input type="checkbox"/>
Head, Eyes, Ears, Nose, Throat, Neck, and Thyroid Gland	<input type="checkbox"/>	<input type="checkbox"/>
Thorax and Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic	<input type="checkbox"/>	<input type="checkbox"/>
Spine	<input type="checkbox"/>	<input type="checkbox"/>
Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Mental Status	<input type="checkbox"/>	<input type="checkbox"/>
Electrocardiogram	<input type="checkbox"/>	<input type="checkbox"/>
Urinalysis	<input type="checkbox"/>	<input type="checkbox"/>
Complete Blood Count	<input type="checkbox"/>	<input type="checkbox"/>
Blood Chemistry Panel	<input type="checkbox"/>	<input type="checkbox"/>

10. Comments: _____

11. Results of tuberculosis skin test: _____

- 12. Sections 112.18 and 943.13, F.S. requires agency knowledge of the following three pre-existing conditions. However, these outcomes do not statutorily disqualify the applicant from employment. Accordingly, please respond to the following: In my professional opinion, this examination:
 - A. Did or did not reveal evidence of tuberculosis.
 - B. Did or did not reveal evidence of heart disease.
 - C. Did or did not reveal evidence of hypertension.

INSTRUCTIONS FOR COMPLETING FORM CJSTC-75A

Please type or print in black or blue ink and use capital and small letters to write names and addresses.

GENERAL INSTRUCTIONS

This form or an equivalent form is to be provided to the examining physician, certified advanced registered nurse practitioner, or physician assistant to use when conducting a physical examination and shall be used in conjunction with the Physician's Assessment form CJSTC-75 or an equivalent form.

Upon completion of the physical, a completed copy shall be provided to the applicant or employing agency.

Employing Agencies Instructions for Completing Form CJSTC-75A

1. **Applicant's Name:** Enter the applicant's full legal name.
2. **Applicant's Address:** Enter the applicant's home address.
3. **Social Security Number (optional):** Enter the last four digits of the applicant's social security as in this example: 000-00-0000.
4. **Hiring Agency:** Enter the hiring agency's name.
5. **Position Applied For:** Enter one of the following disciplines: Law enforcement, correctional, or correctional probation.

Physician's Instructions for Completing Form CJSTC-75A

Note: Indicate the presence of supportive devices by specifying on the provided lines.

1. **Gender:** Enter the sex of the applicant.
2. **Height:** Enter the height of the applicant in inches.
3. **Weight:** Enter the weight of the applicant in pounds
4. **Blood Pressure:** Enter the applicant's systolic and diastolic blood pressure rate.
5. **Resting Pulse:** Enter the applicant's resting pulse rate. Note any irregularities.
6. **Oral Temperature:** Enter the applicant's oral temperature.
7. **Resting Respiratory Rate:** Enter the applicant's resting respiratory rate.
8. **Corrected Visual Acuity** Enter the applicant's corrected visual acuity of the right and left eye.
9. **Physical Examination.** Enter NORMAL or ABNORMAL in the boxes that details the tests and physical examination of the applicant.
10. **Comments:** Enter any additional comments.
11. **Results of the Tuberculosis Skin Test:** Enter the applicant's results of the Tuberculosis Skin Test.
12. Sections 112.18 and 943.13, Florida Statutes, require agency knowledge of the following three pre-existing conditions for potential future disability claims. These outcomes are not disqualifying for employment.
 - A. Place a check mark in the appropriate box to indicate whether the examination did or did not reveal evidence of tuberculosis.
 - B. Place a check mark in the appropriate box to indicate whether the examination did or did not reveal evidence of heart disease.
 - C. Place a check mark in the appropriate box to indicate whether the examination did or did not reveal evidence of hypertension.