NYC Department of Education

OFFICE OF PUPIL TRANSPORTATION
44-36 Vernon Boulevard, 6th floor
Long Island City, NY 11101
Telephone: 718-392-8855

Attendant, EMT, and Para Medical Form

If you knowingly make a false statement on this application, you are committing a misdemeanor and may be subject to prosecution in addition to rejection of your certification to work on a school bus under contract with the NYC Department of Education.

☐ **Attendant** ☐ **EMT** ☐ **Para**

PART 1. PERSONAL INFORMATION - To be completed by applicant

1 First Name	2 Middle Initial	3 Last Name		
4 Social Security Number	5 Date of Birth	6 Marital Status	7 Sex	
8 Current Address	9 Apt/Unit Number	10 City	11 State	12 Zip Code

PART 2. MEDICAL INFORMATION —To be completed by applicant and reviewed by medical examiner

Yes No	Yes No	Yes No
☐ ☐ Any illness or injury in the last 5 years?	☐ ☐ Kidney disease, dialysis	☐ ☐ Stroke or paralysis
☐ ☐ Head/Brain injuries, disorders or illnesses	☐ ☐ Liver disease	☐ ☐ Missing of impaired hand, arm, foot, leg, finger, toe
☐ ☐ Seizures and epilepsy	☐ ☐ Digestive problems	☐ ☐ Spinal injury or disease
☐ ☐ Eye disorders or impaired vision (Except corrective lenses)	☐ ☐ Diabetes or elevated blood sugar controlled by (check all that apply): ☐ diet ☐ insulin ☐ other medication	☐ ☐ Chronic low back pain
☐ ☐ Ear disorders, loss of hearing or balance	☐ ☐ Incident of hyperglycemic or hypoglycemic shock	☐ ☐ Regular, frequent alcohol use
☐ ☐ Heart disease or heart attack; other cardiovascular condition	☐ ☐ Loss of, or altered consciousness	☐ ☐ Narcotic or habit forming drug use
☐ ☐ Heart surgery (valve replacement bypass, angioplasty, pacemaker)	☐ ☐ Fainting, dizziness	☐ ☐ Tuberculosis
☐ ☐ High blood pressure	☐ ☐ Nervous or psychiatric disorders, e.g., severe depression	☐ ☐ Other
☐ ☐ Shortness of breath	☐ ☐ Sleep disorders, pauses in breathing while asleep, daytime sleepiness, obstructive sleep apnea, loud snoring	_____
☐ ☐ Lung disease, emphysema, asthma, chronic bronchitis		_____
		_____

PART 3. MEDICAL INFORMATION — To be completed by medical examiner

PHYSICAL EXAMINATION **Based on Regulation 6.11.01 Commissioner's Regulations**

GENERAL APPEARANCE ☐ Good ☐ Fair ☐ Poor

Note: Visual Acuity of at Least 20/40 Required in Each Eye With Field of Vision of 70 Horizontal Meridian in Each Eye.

VISION For Distance RT	LT	Corrective Lenses	Disease or Injury RT	LT	Color Test	Visual Field RT	LT	BOTH
20/	20/	☐ Yes ☐ No						

Hearing RT	LT	Test Used	Disease or injury RT	LT	Audiometric (if done) Loss at 500 HZ RT	LT	Loss at 1000 HZ RT	LT	Loss at 2000 HZ RT	LT

Nose	Throat	Lungs	Heart	Organic Disease	Compensated	Blood Pressure	Pulse at Rest	After Exercise

Abdomen Scars	Masses	Tenderness	Hernia	Location	Is Truss Worn? ☐ Yes ☐ No	G.I. Ulceration Disease ☐ Yes ☐ No	G.U. Scars	Discharge

Reflexes: Romberg	Pupillary: RT	LT	Knee Jerks: RT ☐ Normal ☐ Increased ☐ Absent	LT ☐ Normal ☐ Increased ☐ Absent

Extremities: Upper	Lower	Spine	Urine: Albumin	Urine: Sugar	If Necessary: Serology	E.K.G.

Radiological Data	Negative Date _____	Positive Date _____	Comments:

I certify that I have examined the above in accordance with the Commissioner's Regulations and with knowledge of his duties. In accordance with Regulation 6.11. I find:

☐ The above named person is physically or medically qualified.

☐ The above named person is not physically or medically qualified because

_____

☐ Restrictions and/or Follow-up
☐ Qualified only wearing corrective lenses
☐ Qualified only when wearing hearing aid
☐ Certification every six months or diabetic condition

_____ (Print Examining Doctor's Name)

_____ (Signature of Examining Doctor)

_____ Date

_____ (Address of Examining Doctor)

8/25/2020

THE CARRIER MUST KEEP A COPY OF THIS EXAMINATION REPORT IN THE EMPLOYEE'S FILE
IF ADDITIONAL SPACE IS REQUIRED, PLEASE USE REVERSE SIDE