

## **Fitness for Life Medical Exam Compliance Form**

Print Name: \_\_\_\_\_ Employee #: \_\_\_\_\_ Item #: \_\_\_\_\_

Rank: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age (as of 2 months from today): \_\_\_\_\_

**To the Clinic Staff:** Please complete the following four sections and give a copy to employee.

- A) Medical Evaluation: If age above (circle one) 25, 30, 35, 40, 42, 44, 46, 48, or 50+, indicate whether participant completed the components listed below.

Completed	Declined	Testing Components
		Blood pressure
		Vision
		Spirometry
		Urine & Blood Testing
		Audiometry
		Medical Questionnaire
		Physical Exam

- B) Physical Fitness Assessment:

Completed	Declined	Testing Components
		Height, weight, waist
		Body fat
		Grip strength
		Sit/reach flexibility

Pushup's		Number Completed in 1 Minute (Goal 24)
Curl Up's		Number Completed in 1 Minute (Goal 35)
Plank Test		Total Number of Seconds Held (Goal 60)

- C) Aerobic Testing:

Age Group	Circle One	<30	30-40	41-50	>50
VO2 Max Target		40	38	36	34

- D) Additional Evaluations: Indicate which were completed:

NONE: \_\_\_ DMV: \_\_\_ HAZMAT: \_\_\_ SCUBA (Westchester only): \_\_\_

My signature below confirms that the tests above have administered to the above named employee consistent with the County of Los Angeles protocols, and that the above information is accurate.

Clinic Name or Stamp: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic Staff Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

**To the Employee:** FAX this form within 24 hours of your exam to the Fire Department HEALTH PROGRAMS OFFICE at (323) 266-8774. Health Programs Phone: (323) 881-3037

**IT IS YOUR RESPONSIBILITY TO CONFIRM RECEIPT.**