

 IDJC POST-CERTIFIED EMPLOYEE MEDICAL EXAM REPORT

Employee’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Provided by HR)

Employee’s Date of Birth: \_\_

### To the employee: Acceptance to the IDJC POST Academy requires that a complete medical examination be performed by a Licensed Physician or his designee within 60 days of employment. Additionally, a medical certification is required every five years for employees in a POST-certified position. It is your responsibility to make sure all medical forms are completed thoroughly and signed in the appropriate places. Complete and present the Health Questionnaire and this form to your physician for their review. After the physician has completed this form, return it to Human Resources at IDJC Headquarters office. Leave the Health Questionnaire form (DJC-284) with your physician.

**To the examining physician:** The above-named employee has been selected for an Idaho Department of Juvenile Corrections POST-certified position and will participate in a training academy or is currently employed in a POST-certified position and requires medical certification to perform the required duties.

**Please check the appropriate box below:**

####  I have reviewed the Health Questionnaire form (DJC-284) submitted to determine if the employee is free from any physical impairment, emotional or mental condition, free of any signs/symptoms of communicable disease likely to infect others in an academy or institutional (enclosed) environment, or any other condition which might adversely affect the employee’s ability to train or safely perform the duties of a POST-certified employee.

 The employee did not provide a completed Health Questionnaire.

A thorough medical examination is required prior to acceptance as an Idaho Department of Juvenile Corrections POST-Certified employee and every five years. Employees are **required to participate in vigorous self-defense and physical development exercises** during Academy Training and as part of their job duties.

**Required Physical Abilities:** Static, dynamic and trunk strength, extension and dynamic flexibility, manual and finger dexterity, arm-hand steadiness, gross body coordination, speed of limb movement and mobility.

#### Acting alone, this employee, in their area of expertise, must be able to:

|  |  |
| --- | --- |
| Pursue people on foot | Utilize observation skills |
| Use Appropriate Use of Force to restrain another person(s) | Identify drugs and paraphernalia |
| Use restraining devices | Report physical and sexual abuse |
| Respond to high-risk situations | Interview people/Write reports |
| Operate emergency radios | Assess hazards |
| Verbally negotiate with people | De-escalate volatile situations |
| Conduct searches of people and buildings | Provide emergency first aid |

**Operate:** Mechanical tools, computers, and handcuffs.

**Work Long Hours:** While seated, standing, bending, reaching, pushing, kneeling, pulling, lifting, turning and standing, turning and sitting.

# A participant in the Idaho Department of Juvenile Corrections POST Academy or who is employed in a POST-certified position must be free of any communicable disease that would be likely to infect others in an enclosed environment.

#### PLEASE ANSWER ALL QUESTIONS—INCOMPLETE FORMS WILL BE RETURNED

**PHYSICIAN STATEMENT AFTER EXAMINATION:**

**Please initial the appropriate response**

 I, or my designee, have examined the above-named employee and find him/her free of any communicable disease.

 It is ***my opinion*** that the employee ***IS* physically able** to perform the full duties required of a POST-certified employee, as outlined above.

 It is ***my opinion*** that the employee ***IS Not Currently* physically able** to perform the full duties required of a POST-certified employee, but may become physically able to perform those duties with recommended action/treatment. Please see details below.

 It is ***my opinion*** that the employee ***IS NOT*** *(and is not likely to become)***physically able** to perform the full duties required of a POST-certified employee for the reasons stated below.

# Signature of Examiner Date of Exam

**Printed Name of Examiner**

### IMPORTANT! Type or stamp physician’s name, address, and telephone number in the space below: