



City of Albuquerque

HUMAN RESOURCES

Background Investigation Waiver and Release Form

In connection with my application of employment with the City of Albuquerque, hereby known as "Hiring Entity" I understand that investigative reports may be requested that will include information as to my performance and experience along with reasons for termination of past employment from previous employers. Further, I understand that information may be requested concerning my motor vehicle registration history and criminal history from various states, private insurance sources along with other public records available.

I voluntarily and knowingly authorize any present or past employer or supervisor, institution of learning; administrator, law enforcement agency, local or state agency, Federal agency; private business; military branch or the National Personnel Records Center to give records of information they may have concerning information requested as part of my background investigation. I voluntarily and knowingly unconditionally release any named or unnamed format from all liability resulting from the furnishing of this information. A photocopy of this Designation and Authorization for Release and Rediscovery of Information shall be considered by the recipient to be a signed original, as long as it is transmitted to the recipient by the Hiring Entity and is received within one year of the signature date,

I understand that a thorough and complete background investigation will be conducted to determine my fitness and desirability as a candidate for employment or as a volunteer. I hereby release from liability and agree to hold harmless; under any and all possible cause of legal action, including negligence, the City of Albuquerque, the Agency and any of its officers, agents or employees for any neglect or wrongful statements, acts, omissions made or recorded in the course of my background investigation.

If I am denied employment, either wholly or partly because of information contained in resulting reports, a disclosure will be made to me of the name and address of the consumer reporting agency making such report. If the report contains information about me that is matter of public record, such as arrests, indictments or convictions, I may also be informed of the name and address of any person to whom the information is reported.

Applicant Signature Date

Parent/Guardian Signature (If under 18) Relationship Date

APPLICANT INFORMATION – Please complete ALL blanks

Last Name First Name Full Middle Name Social Security Number

Maiden Name Other Names, Nicknames or Aliases used Date of Birth (Month/Day/Year)

Present Address Number/Street/Quadrant City State Zip Code How Long

Previous Address (Within last 7 years) Number/Street/Quadrant City State Zip Code How Long

Driver's License Number State Issued Expiration Date Operator Commercial (CDL)

City of Albuquerque Information:

Department/Job Title: _____ / _____ Department No: _____

Position Applying for: _____ Requested BY: _____



City Of Albuquerque Medical/Occupational History

Return completed form to Employee Health Center

Located on the Basement Level of Old City Hall
400 Marquette NW
768-4630

This physical exam is intended to verify your physical capability to perform the job for which you are being hired. It is not intended to take the place of exams given by your personal physician.

Name: _____ Date: _____
(Last) (First) (Initial)

Social Security Number: _____ Date of Birth: _____

Reason for exam: Post-offer Annual Other

Who is currently your Primary Care Physician? Name: _____

Please Check any of these items to which you have had exposures or needed medical treatment:

- | | | | |
|--|---|---|--------------------------------|
| <input type="checkbox"/> Asbestos | <input type="checkbox"/> PCB, PBB | <input type="checkbox"/> Vapors/Gases | <input type="checkbox"/> Other |
| <input type="checkbox"/> Blood/Body fluids | <input type="checkbox"/> Metals (fumes/dusts) | <input type="checkbox"/> Vibration | |
| <input type="checkbox"/> Dusts | <input type="checkbox"/> Noise | <input type="checkbox"/> Heat/Cold Exposure | |
| <input type="checkbox"/> Radiation | <input type="checkbox"/> Carcinogens | <input type="checkbox"/> Pesticides | |

If **YES** to any of the above, describe below including a complete description of the exposure, dates of occurrences and name of physician who treated you. Also list place of employment, if exposure occurred in a work environment.

1. Have you ever been injured on the job in any way?..... Yes No
2. Have you ever gotten sick in any way from something you worked with on the job?. Yes No
3. Has your work ever caused problems with your joints(Wrists, etc.), your back or skin?..... Yes No
4. Have you had any hobbies or jobs in which you use chemical, metals, loud machines or tools, firearms, music amplifiers or other hazardous substance?..... Yes No
5. Have you ever claimed Worker's Compensation Benefits? If **YES**, explain below..... Yes No

6. Have you ever had to terminate any job for health reasons?.....Yes No
7. Have you ever had to transfer from one job to another or change job duties for health reasons? Yes No
8. Have you ever been refused any job for Health reasons?..... Yes No
9. Has a doctor ever placed restrictions on the kind of work you should do?..... Yes No
10. Has a doctor ever placed restrictions on your lifting, bending, twisting, walking, standing, sitting or using Your hands, arms or back?..... Yes No
11. Have you ever had a back injury or experienced back pain or back strain?..... Yes No
12. Have you ever filed a lawsuit for any injury?..... Yes No

ALLERGIES

List any allergies you have to drugs, foods, pollen, etc.

REVIEW OF SYSTEMS

1. Yes No Problem with overall fitness and feeling of well-being?
 Unexplained fever Unexplained weight loss/ gain Unusual sweating Weakness Fatigue

2. Yes No Problems with skin?
 Recurrent or persistent rash Unexplained itching Eczema
 Allergic skin rash Acne Psoriasis Dry cracked skin
 Yellow color

3. Yes No Problem with Blood or Bleeding?
 Anemia (Low blood count) Nose Bleeds Bruising
 Bleeding trait

4. Yes No Problems with Diabetes?

5. Yes No Problem with Muscles, Joints, Back?
 Painful, stiff or swollen joints Arthritis Gout
 Back Pain Back injury Sciatica Sore Muscles

6. Yes No Problem with Eyes or Vision?
 Wear Glasses/Contacts Loss of vision Lazy eye
 Glaucoma Cataracts Yellow eyes

7. Yes No Problem with Ears or Hearing?
 Ringing or buzzing in the ears Loss of hearing Ear infection

8. Yes No Nose and throat Problems?
 Sinus trouble Hay Fever Recurrent sore Throats

9. Yes No Breathing or Lung Problems?
 Shortness of Breath Persistent Cough Bronchitis Tuberculosis
 Coughing up blood Coughing up sputum Wheezing (Asthma)

10. Yes No Problem with the Heart or Blood Vessels?
 Rheumatic Fever Heart Murmur Palpitations Chest pain
 Phlebitis Heart attacks Angina Heart failure
 Varicose veins Unusually rapid heart beat

11. Yes No High blood pressure?
12. Yes No Problem with Stomach, Liver, or Bowels?
 Stomach/Abdominal pain/discomfort Stomach Ulcer
 Blood in stool Cirrhosis Recent change in bowel habits
 Hepatitis Heartburn Gallbladder Trouble
 Persistent diarrhea Hernia Yellow Jaundice
13. Yes No Problem with Bladder or Kidneys?
 Urine infection Frequent Urination Kidney stones
 Painful Urination Blood in the Urine Difficulty Urinating
 Kidney Failure
14. Yes No **(Men)** Problem with the Male Organs?
 Infertility (Inability to have children) Trouble with sexual
Performance Prostate infections Prostate enlargement
 Lump on Testicle
15. Yes No **(Women)** Problem with Female Organs?
 Infertility (Inability to have children) Pelvic infections
 Painful Periods Missed, Irregular, Prolonged periods
 Breast Lumps or Discharge
16. Yes No **(Women)** Are you Pregnant now?
17. Yes No Problems with the Nervous system?
 Seizures or convulsions Headaches
 Fainting or blackouts Numbness or Loss of Sensation
 Weakness of Arm or Leg Stroke
18. Yes No Emotional or Mental Problems?
 Depression Anxiety Nervous Breakdown
19. Yes No Any other Problems with pain?
 Pain/Discomfort in the chest Pain in the Arms, Wrists,
Legs, or Back
20. Yes No Any Swelling in the Legs?

HEALTH MAINTENANCE RECORD

Are you now under the care of a physician for a health condition?..... Yes No

If **YES**, what is the condition(s)? _____

When did you last have any of the following?

| | Date | Where | Results (if Applicable) |
|-------------------|-------------|--------------|--------------------------------|
| Physical Exam | _____ | _____ | _____ |
| Eye Exam | _____ | _____ | _____ |
| Chest X-ray | _____ | _____ | _____ |
| Back X-ray | _____ | _____ | _____ |
| Other X-ray/MRI | _____ | _____ | _____ |
| Tetanus shot | _____ | _____ | _____ |
| Tb Test | _____ | _____ | _____ |
| Hepatitis vaccine | _____ | _____ | _____ |

Have you ever received instruction in back care and lifting techniques?..... Yes No

Females: Pap Smear _____
Breast exam _____

Have you ever been instructed in breast self-examination?..... Yes No

PAST MEDICAL HISTORY

- | | | |
|---|------------------------------|-----------------------------|
| Have you ever been Hospitalized? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have any physical impairments? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Were you born with any physical defect? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had surgery? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever broken a bone? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If **YES**, to any of the above, list the specific details including dates and names of treating physician.

FAMILY HISTORY

Have any of your parents, Brothers and/or Sisters ever had?
 High Blood pressure Heart problems Stroke Diabetes

- Cancer
- Alcoholism

Bleeding disorder

Mental disorder

MEDICATIONS

List any Medicines including over the counter medicine you are taking?

- 21. History of any kind of cancer? Yes No
- 22. Persistently swollen Lymph Glands? Yes No
- 23. Problem with Thyroid Gland? Yes No
- 24. Any other Health problems? Yes No

Use this space to explain any problem or to complete other sections as needed.

I certify the information contained in this record is correct and complete to the best of my knowledge and belief. I understand that knowingly making **a false statement** in this record shall be deemed sufficient cause for **rejection of my application** or **dismissal after employment**. I understand I shall be entitled to **no future worker's compensation** benefits if I knowingly and **Willfully conceal** or make **false representation** about the information requested. I understand that the City Of Albuquerque will rely on this Medical and Occupational History.

I AUTHORIZE THE CITY OF ALBUQUERQUE, NOW AND IN THE FUTURE, TO OBTAIN ANY MEDICAL RECORDS WHICH ARE REASONABLY RELATED TO MY ABILITY TO DO MY JOB.

To ensure compliance with Right to Privacy Laws, this form must be Sealed in the envelope provided and hand delivered to the Employee Health Center on the day of your physical, and/or drug test. If Pre-employment requirements do not include a physical and/or drug test this form must be hand delivered to the Employee Health Center prior to your first day of work.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT.

(Signature of Applicant)

(Date)