

# GENESEE COUNTY WORKMEN'S COMPENSATION

## CERTIFICATE OF HEALTH

(To be filled out in employee's own handwriting)

Please answer all the following questions:

Fire Company \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ ft \_\_\_\_\_ in Weight \_\_\_\_\_

To the best of your knowledge, or belief, has any member of your family, including your grandparents, parents, brothers or sisters, ever had:

	YES	NO
Tuberculosis		
Insanity		

	YES	NO
Epilepsy		
Heart Disease		

Are you suffering from, or have you ever suffered from any of the following ailments?

	YES	NO
Frequent Severe Headache		
Shortness of Breath		
Swelling of Feet		
Blood in Urine		
Varicose Veins		
Diabetes		
Hemorrhoids (Piles)		
Asthma		
Epilepsy		

	YES	NO
Skin Disease		
Back Pain		
Arch or Feet Trouble		
Rupture or Hernia		
Paralysis		
Heart Disease		
Tuberculosis		
Other Lung Trouble		
Lead or Other Poisonings		

Remarks explaining any of the above:

When were you treated last by any physician or doctor? \_\_\_\_\_

What were you treated for? \_\_\_\_\_

Name and Address of doctor: \_\_\_\_\_

Have you ever had an injury in which has left any part of your body deformed or stiff? \_\_\_\_\_

If so, what? \_\_\_\_\_

Have you ever drawn Workmen's Compensation Benefits? \_\_\_\_\_

Who was your employer? \_\_\_\_\_ Approximate Date \_\_\_\_\_

\_\_\_\_\_  
(Signature of Volunteer Fireman)

State of New York      SS:  
County of Genesee

\_\_\_\_\_ being duly sworn, deposes and says that he has read the foregoing statement by him subscribed and knows the contents there of and that the same is true to the best of his knowledge and belief.

\_\_\_\_\_  
Notary Public

This form is to be returned to:  
Office of the Executive Secretary, Genesee Counter Self-Insured Plan, Co. Bldg #1, Batavia, New York, 14020