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www.SBCounty.gov

SAN BERNARDINO COUNTY

Human Resources
Center for Employee Health and Wellness

MEDICAL HISTORY UPDATE

Name	Other Names Used	Today's Date
Employee ID	Phone Number	Date of Birth
Mailing Address *Street, City, State, Zip Code*		
Personal Email Address	Work Email Address	
Department	Job Title	

What is the medical condition/procedure/surgery or other that you are being evaluated for today? Please explain in detail:

_____

_____

_____

In relation to the above medical condition/procedure/surgery or other, do you have any work restrictions? If yes, please explain in detail: ☐ Yes ☐ No

_____

_____

_____

I certify that the information given by me is true, correct, and complete to the best of my knowledge and belief. I understand that any material misstatements or omissions of facts may lead to disciplinary action and/or loss of employment with San Bernardino County, either before or after such employment has commenced.

Employee Signature: _____ Date: _____

Consent for Medical Care: The undersigned consents to having a return-to-work evaluation.

Employee Signature: _____ Date: _____

Witness Signature: _____ Date: _____