Page 1-6 of this form is NOT to be returned to employer.

Instructions to Employee: Please complete all the questions in this packet and provide it to the Physician at the time of your physical. Attached is the Job Requirements and Physical Capabilities for the Physicians review.

MEDICAL HISTORY QUESTIONNAIRE

I herewith affirm that the employer has made an offer of employment to me, conditioned on the satisfactory completion of this questionnaire, and, if necessary, at the sole discretion of the employer, a medical examination.

The purpose of this inquiry is to determine whether I currently have the physical or mental qualifications necessary to perform the job that has been offered; whether and what accommodations may be necessary; and whether I can perform the job without posing a direct threat to the health or safety of myself or others; and for the purposes and reasons as stated on the attached questionnaire.

This information will be kept confidential in a separate medical file, apart from my personnel file. I herewith affirm that the questions found in the attached medical questionnaire have not been asked of me by anyone with the employer until after I have signed this statement and have been offered a job.

Name: _____

Social Security Number: _____

Signature: _____

I, the undersigned applicant, do hereby certify that the information provided to me for the purpose of employment is true and complete to the best of my knowledge. I understand that if I am employed and any false statements will be considered as cause for possible dismissal.

1. Have you ever had or been treated for any of the following conditions or diseases?

	Yes	No
Epilepsy		
Diabetes		
Cardiac disease (heart trouble)		
Amputation of foot, leg, arm or hand		
Total loss of sight of one or both eyes or a partial loss of corrected vision of more than 75 percent bilaterally		
Residual disability from poliomyelitis (polio)		
Cerebral palsy		
Multiple sclerosis		
Parkinson's disease		
Hemophilia		
Chronic osteomyelitis (bone infraction)		
Hyperinsulinism (low blood sugar)		
Muscular dystrophy		
Thrombophlebitis (Inflammation of a vein with a blood clot formed in the vein)		
Herniated intervertebral disk (slipped disk)		
Surgical removal of an intervetebral disk or spinal fusion		
Total deafness		
Mental retardation		
Meniscectomy		
Patellectomy		
Ruptured Cruciate Ligament		
Surgical or Spontaneous Fusion of a major weight bearing joint		
One or more back injuries or diseased process of the back resulting in disability over a total of 120 or more days		
Prior industrial accidents with this company or affiliated company		
Any permanent physical condition which constitutes a 20 percent impairment of a member or of the body as a whole		
Rheumatic fever		
High blood pressure		
Varicose veins or leg ulcer		
Chest pain		
Tuberculosis		
Allergies		
Hay fever or Asthma		
Skin trouble		
Reaction to serum or drug		
Kidney or bladder trouble		
Ulcers		
Head injury		
Cancer		
Dizziness or fainting spells		
Arthritis or rheumatism		
Knee injury		
Backache		
Shoulder injury		

	YES	NO
Alcoholism		
Drug addiction		
Severe headaches		
Chronic cough		
Shortness of breath		
Nervous breakdown		
Mental illness, psychiatric treatment or professional counseling		

2. Please list any condition or diseases for which you have been treated in the past 3 years. If no treatment has been provided, state "none." _____

3. Have you ever been hospitalized? If so, for what condition? If you have not been hospitalized, if none, state none."_____

4. Has a psychiatrist or psychologist ever treated you? If so, for what condition? If no such treatment has been received state "none."_____

5. Have you ever been treated for any mental condition? If no such treatment has been received, state "none." _____

6. Is there any health-related reason you may not be able to perform the job for which you are applying? If yes, please explain. _____

7. Have you had a major illness in the past 5 years? If none, state "none."
_____

8. How many days were you absent from work because of illness last year? If none, state "none." _____

9. Do you have any physical defects, which preclude you from performing certain kinds of work? If yes, describe such defects and specific work limitations. If none, state "none."
_____

10. Do you have any disabilities or impairments, which may affect your performance in the position for which you are applying? _____

11. Are you taking any prescribed drugs? If yes, state the medication and the reason for taking it. If no medications are being taken, state "none." _____
_____

12. Have you ever been treated for drug addiction or alcoholism? If yes, identify the medical care provider and dates of treatment. If no treatment has been provided, state "none."
_____

13. Have you ever filed for workers' compensation insurance? _____

14.

a. Do you know of any condition (physical or mental) that you have which could affect or interfere with your ability to safely perform the essential job functions?

_____ YES _____ NO

b. If "YES," describe all accommodations necessary for you to safely perform the essential job functions

Job Function: _____

_____

Accommodation: _____

_____

15. Describe all job functions, which you feel you may be unable to safely perform, including all functions that may affect your safety or the safety of others, and other functions, which may aggravate or worsen a past or present condition.

a. If no accommodations are made, I may be unable to perform the following functions safely

_____

_____

_____

_____

b. Even if the accommodations noted in (b.) (2) above are made, I may be unable to safely perform: _____

_____

_____

_____

16. Describe any condition or concern not otherwise noted above which you have, or which we should be aware, regarding your physical and mental ability to meet the essential job functions of the position.

_____

_____

By signing below I acknowledge that I have read, understand and agree to the above, and have accurately completed this form to the best of my ability.

_____ _____

Applicants Signature Date

SAMPLE JOB- each packet should contain the proper job description per employer.

Test 1
You will be asked to lift a crate from a 30" table to another 30" shelf at a distance of 1 foot from the table. The crate is then put back to the original spot on the table. The crate will initially be empty. On each additional repetition a 25 pound weight will be added to the crate. This will continue until you are unable to safely lift the weight or reach 90 pounds, at which time you will be asked to complete a total of 3 repetitions with the 90 pounds.

Test 2
You will be asked to lift an empty crate from a thirty inch table to an "overhead" shelf. The crate is then placed back on the table. On the next repetition a 25 pound weight will be added to the crate. An additional 25 pound weight will be added, at which time you will be asked to complete a total of 3 repetitions with 50 pounds of weight in the crate. You will be stopped if unable to safely lift the weight at any time.

Test 3
You will be asked to stand on one leg for 30 seconds. You will be asked to stand on the other leg for 30 seconds. You must stay on the one leg the entire 30 seconds to pass.

Test 4
You will be asked to be in the kneeling position. You will be asked to squeeze a hand dynamometer, 5 times with each hand. To pass the test you need to consistently generate 90 pounds of force with each hand. R ____ _____ _____ _____ _____
L ____ _____ _____ _____ _____

******For all testing, you should stop if you feel ill in any way or experience any kind of pain. You should not perform testing if you are pregnant. If you have a history of heart disease or other serious medical condition, you should consult a physician prior to testing.

By signing below, you indicate that you understand how you will be expected to perform the tests, that your questions have been answered and that you are ready for the testing.

Signature of Applicant: _____ **Witness:** _____

Test Results	**Pass**	**% Completed**	
Test 1		___	___
Test 2		___	___
Test 3		___	___
Test 4		___	___

Signature & Date of Tester: _____

Only this form is to be returned to the employer.

Report of Pre-Placement Medical Evaluation

To: _____

I have examined _____

For the ability to perform the essential functions of the job as indicated in the attached job requirements and physical capabilities.

Based on my evaluation of this job candidate:

____ (1) No medical contraindication to performing this job without accommodation.
____ (2) No medical contraindication to performing this job with the following recommended accommodations or job training:
_____

_____

____ (3) Based upon probability of substantial harm, this employee could pose a direct threat to self or others.
____ (4) Medical hold; waiting for additional data.
____ (5) Further testing is required to fully evaluate ability or risk.

Comments: _____

_____

_____

If 2, 3, or 5 are checked, please call me to discuss further, including recommendations for other information that may aid in accommodations or clarification of risk.

Treat any attached information on medical conditions as confidential medical information in accordance with the Americans with Disabilities Act, with distribution only as needed.

_____ _____
Signature of Physician Date