

POST OFFER OF EMPLOYMENT MEDICAL INQUIRY

Responses to these questions are completely confidential and will be utilized only if necessary to determine if any reasonable accommodation is required for any work you may perform, whether any health condition may pose a direct threat of injury to yourself or others, to assist with treatment of any work-related injury, or for any other lawful purpose.

Name: _____ Department: _____ Position: _____

To the best of your knowledge, do you have or have you had any of the following medical conditions?
(For "yes" responses, indicate the nature of injury or illness and name of physician in the remarks section.)

Answer YES or NO:

- | | |
|--|--|
| <input type="checkbox"/> 1. Epilepsy | <input type="checkbox"/> 19. Compressed air sequelae |
| <input type="checkbox"/> 2. Diabetes | <input type="checkbox"/> 20. Shoulder injury or problems |
| <input type="checkbox"/> 3. Arthritis | <input type="checkbox"/> 21. Back conditions (identify below) |
| <input type="checkbox"/> 4. Amputated foot, leg, arm
or hand | <input type="checkbox"/> a. back injury |
| <input type="checkbox"/> 5. Loss of sight of one or both
eyes or a partial loss of sight | <input type="checkbox"/> b. back pain which required
medical treatment |
| <input type="checkbox"/> 6. Residual disability from
Polymyelitis | <input type="checkbox"/> c. back surgery |
| <input type="checkbox"/> 7. Cerebral palsy | <input type="checkbox"/> d. degenerative disc disease |
| <input type="checkbox"/> 8. Multiple sclerosis | <input type="checkbox"/> e. multiple back strains |
| <input type="checkbox"/> 9. Parkinson's disease | <input type="checkbox"/> f. chronic back pain |
| <input type="checkbox"/> 10. Cardiovascular disorders | <input type="checkbox"/> g. herniated disc |
| <input type="checkbox"/> 11. Tuberculosis | <input type="checkbox"/> 22. Neck conditions (identify below) |
| <input type="checkbox"/> 12. Mental disability
following confinement for
treatment in a recognized
medical or mental institution
for a period in excess of six
months | <input type="checkbox"/> a. neck injury |
| <input type="checkbox"/> 13. Hemophilia | <input type="checkbox"/> b. neck pain which required
medical treatment |
| <input type="checkbox"/> 14. Sickle cell anemia | <input type="checkbox"/> c. neck surgery |
| <input type="checkbox"/> 15. Chronic osteomyelitis | <input type="checkbox"/> d. degenerative disc disease |
| <input type="checkbox"/> 16. Ankylosis on major weight-bearing
joint. | <input type="checkbox"/> e. multiple neck strains |
| <input type="checkbox"/> 17. Muscular dystrophy | <input type="checkbox"/> f. chronic neck pain |
| <input type="checkbox"/> 18. Hearing loss | <input type="checkbox"/> g. herniated disc |
| | <input type="checkbox"/> 23. Knee conditions (identify below) |
| | <input type="checkbox"/> a. left knee surgery |
| | <input type="checkbox"/> b. right knee surgery |
| | <input type="checkbox"/> c. other (explain) |
| | <input type="checkbox"/> 24. Hip replacement surgery |
| | <input type="checkbox"/> 25. Swelling of any joint which required
medical treatment |
| | <input type="checkbox"/> 26. Hernia |
| | <input type="checkbox"/> 27. Carpal Tunnel Syndrome |
| | <input type="checkbox"/> 28. Surgery (explain) |

Remarks: _____

I, _____ (Employee), attest that the above information is true and complete to the best of my knowledge.

Signature of Employee _____ Date _____

Signature of Employer _____ Date _____