POST-JOB OFFER MEDICAL QUESTIONNAIRE

Employee Name:
Date of Birth:
Address (Street, State, Zip):
Emergency Contact Name:

Social Security Number:
Phone Number:

Emergency Contact Number:

NOTICE TO OFFEREES: In compliance with the Americans with Disabilities Act of 2008 (ADA), you have received a conditional offer of employment. This medical history statement is required of all offerees. The answers to the medical history statement and any medical examination will be kept confidential and in separate files in compliance with the ADA requirements. The job offer, which you have received, is conditioned upon satisfactory completion and review of this medical questionnaire and any required medical examination or follow up.

GINA DISCLOSURE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

EMPLOYEE AFFIRMATION: I herewith affirm that the employer has made me an offer of employment, conditioned on, among other things, the satisfactory completion of this questionnaire. The purpose of this inquiry is as follows: (1) to determine whether I currently have the physical qualifications necessary to perform the essential functions of the job that has been offered; (2) to determine what accommodations, if any, may be necessary for me to perform the essential functions of the job; and (3) to determine whether I can perform the essential functions of the job without posing a significant direct threat to the health and safety of myself and others. This information will be kept strictly confidential in a separate medical file (though managers and supervisors may be told about necessary restriction or accommodations, first aid and safety personnel may be told if emergency treatment might be required, and information may be shared with certain government officials)., apart from my personnel file. I hereby affirm that the questions in the medical questionnaire have not been asked of me by anyone with the employer until after I have signed this statement and been given a conditional offer of employment. The job duties of the position for which I have received a conditional offer have been adequately described to me, and I have had an opportunity to ask questions regarding the duties.

EH NOTES:

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

☐ **Surgery**

☐ **Herniated Disc**
☐ **Surgical removal of disc or spinal fusion**
☐ **Hernia or rupture**
☐ **Neck Injury, pain, or problems**
☐ **Shoulder Injury**
☐ **Arm/Hand Injury**
☐ **Repetitive Motion Disorder Tendinitis**
☐ **Amputations**
☐ **Asthma**
☐ **Back pain**
☐ **Diabetes**
☐ **Heart attack**
☐ **Hepatitis, cirrhosis or liver disease**
☐ **Musculo-skeletal problems**
☐ **Shortness of breath**
☐ **T.B. positive**
☐ **Wear glasses/contacts**
☐ **Knee Injury**
☐ **Back Injury**
☐ **Diseased process of the spine**
☐ **Chest Pain**
☐ **Arthritis or Rheumatism**
☐ **Wrist Problems (Including Carpal Tunnel)**
☐ **Broken Bones**
☐ **Head Injury**
☐ **Epilepsy, fainting spells, or dizziness**
☐ **Serious allergies**
☐ **Bronchitis**
☐ **Emphysema**
☐ **Heart disease**
☐ **Jaundice**
☐ **Nose bleeds**
☐ **Sleep disorders**
☐ **Vision problems**
☐ **Ankylosis (immobility) of any major weight bearing joints (ankle, knee, hip)**

2. Have you sought treatment from a healthcare provider for any of the above injuries and/or medical conditions?
YES ☐ NO ☐

3. Are you capable of performing the essential functions of this position with or without a reasonable accommodation?
YES ☐ NO ☐

If 'YES' do you require an accommodation? YES ☐ NO ☐ If 'Yes' what accommodation do you need:

4. Do you have any injury or condition that requires a reasonable accommodation in order for you to perform the essential functions of this position?
YES ☐ NO ☐

If 'YES' what accommodations do you need to perform the essential functions of the position:

5. Please indicate the amount of weight you can comfortably lift unassisted:

<15 lbs ◯ 15-25 lbs ◯ 25-40 lbs ◯ >40lbs ◯

6. Are you currently restricted or limited in your ability to sit, stand, push, pull, or lift anything at the direction of a healthcare provider?
YES ☐ NO ☐

If 'YES' what are the restrictions or limitations:

7. Has a Healthcare Provider limited the amount of weight you can lift?
YES ☐ NO ☐

If 'YES' what is that limit:

8. Are you taking any prescribed drugs or medications that would interfere with your ability to perform your job?
YES ☐ NO ☐

If 'YES' what drugs or medications are you taking:

I attest that the information provided in this questionnaire in connection with my offer of employment are accurate, complete, and provided willingly and intentionally. I understand that failure to disclose relevant information related to any of these questions could negatively effect my employment.

NAME

DATE

EH Nurse Signature:

Date: