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POST-JOB OFFER MEDICAL QUESTIONNAIRE

Employee Complete and Sign (please print clearly): Page One of Two

Employee Name: _____ _____ _____
First Name *Middle Initial* *Last Name*

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.

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, 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 offered a conditional job. The conditional job duties have been adequately described to me, and I have had an opportunity to ask questions regarding the duties.

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

Herniated Disc	☐ YES	☐ NO
Knee injury	☐ YES	☐ NO
Surgical removal of disc or spinal fusion	☐ YES	☐ NO
Back injury	☐ YES	☐ NO
Hernia or rupture	☐ YES	☐ NO
Diseased process of the spine	☐ YES	☐ NO
Neck injury, pain or problems	☐ YES	☐ NO
Chest Pain	☐ YES	☐ NO
Shoulder injury	☐ YES	☐ NO
Arthritis or rheumatism	☐ YES	☐ NO
Arm/hand injury	☐ YES	☐ NO
Wrist problems, including Carpal Tunnel Syndrome	☐ YES	☐ NO
Repetitive motion disorders	☐ YES	☐ NO
Broken bones	☐ YES	☐ NO
Ankylosis (immobility) of any major, weight-bearing joints (ankles, knees, hips)	☐ YES	☐ NO
Tendonitis	☐ YES	☐ NO
Head injury	☐ YES	☐ NO
Amputations	☐ YES	☐ NO
Epilepsy, fainting spells, or dizziness	☐ YES	☐ NO

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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 duties of this job function?** ☐ YES ☐ NO

Do you have any injury or condition that requires a reasonable accommodation in order for you to be able to perform the essential duties of this job position? ☐ YES ☐ NO

If "YES", what accommodations do you need to perform the job?

4. **How much weight can you lift comfortably unassisted?**

◯ < 15 lbs ◯ 15-25 lbs ◯ 25-39 lbs ◯ ≥ 40 lbs

5. **Has a healthcare provider placed any limitations on your ability to sit, stand, push, pull, or lift?**

☐ YES ☐ NO

If "YES", what are the limitations?

6. **Has a healthcare provider limited the amount of weight you can lift?** ☐ YES ☐ NO

If "YES", list the weight limitation and the date that your healthcare provider issued you the limitation?

7. **Are you taking any prescribed drugs that would interfere with your ability to safely perform your job?**

☐ YES ☐ NO

If yes, please list the medications.

My signature certifies that all facts and representations made by me are true, accurate and made willingly and intentionally.

_____ _____ _____

Signature Print Your Name Date

_____ _____

Company Representative Date