StaffCo

POST-OFFER MEDICAL QUESTIONNAIRE

EMPLOYEE INFORMATION

Name:		
SSN:	Date of Birth:	Height/Weight:

EMERGENCY CONTACT INFORMATION

Name:		Relationship:
Home Phone:		Mobile Phone:
Address:		
City:	State:	Zip:

By completing this form, I am verifying that StaffCo has already presented a conditional job offer to me. We must have prior knowledge of any pre-existing illness or other ailment / injury you may have sustained in the past that may contribute to a percentage of permanent impairment. The presence of one or more impairments does not automatically render you as an unfit employee. All decisions will be made on job-related criteria. Reasonable accommodation will be made if appropriate, provided it does not pose an undue hardship upon the Company making the conditional job offer.

CIRCLE THE APPROPRIATE YES OR NO

Yes	No	Asthma	Yes	No	Tendonitis
Yes	No	Hay fever	Yes	No	Muscular dystrophy
Yes	No	Migraine headaches	Yes	No	Repetitive motion disorder
Yes	No	Diabetes	Yes	No	Ruptured disc
Yes	No	A head injury	Yes	No	Stiffness of major weight-bearing joints
Yes	No	Color blindness	Yes	No	Nervous trouble or treatment
Yes	No	A fear of heights	Yes	No	Kidney problems
Yes	No	An amputated foot, leg, arm, or hand	Yes	No	Depression
Yes	No	Heart trouble	Yes	No	Knee problems
Yes	No	Loss of sight in one or both eyes	Yes	No	Hyperinsulinism (hypoglycemia)
Yes	No	Fainting spells or dizziness	Yes	No	Pulmonary disease

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CIRCLE THE APPROPRIATE YES OR NO

Yes	No	Cerebral palsy	Yes	No	Ankylosis (immobility) of ankles, knees, hips
Yes	No	Swelling of the legs or ankles	Yes	No	Partial loss of hearing
Yes	No	Multiple sclerosis	Yes	No	Cardiovascular disorder
Yes	No	Skin rashes or eczema	Yes	No	Epilepsy
Yes	No	Parkinson's disease	Yes	No	Tuberculosis
Yes	No	Joint pains or arthritis	Yes	No	Hemophilia
Yes	No	Cancer	Yes	No	Sickle cell anemia
Yes	No	Mental retardation	Yes	No	Chronic bone infection
Yes	No	Varicose veins	Yes	No	Carpal tunnel syndrome

PLEASE ANSWER THE FOLLOWING QUESTIONS

Do you need glasses to read or to see long distances?

Have you ever had an audiogram (hearing test)? If yes, please list results.

Have you ever broken any bones? Please include which bones and when.

Do you take medication to control high blood pressure?

Have you experienced any serious injuries? Please include when it occurred and the nature of the injury.

Have you experienced a hernia or rupture? When did it occur?

Have you experienced neck pain or problems? When did your neck problems occur?

Have you ever injured your back? When did the injury occur?

Have you ever experienced compressed air sequelae (damage to the lungs, ruptured ear drum, etc.) due to an explosion or concussion?

Have you ever refused surgery? If yes, why?

Do you currently take any prescription medications? If so, please list.

Do you have any condition or have you sustained any injuries that would have an effect on your capacity to perform the duties of this position without reasonable accommodation?

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HAVE YOU EVER HAD:

Yes	No	An allergic reaction to any drugs? Which drugs?
Yes	No	Partial loss or uncorrected vision of more than 75% bilaterally?
Yes	No	Psychoneurotic disability following confinement for treatment in a recognized medical or mental institution for a period in excess of six months?
Yes	No	Any permanent condition that constitutes 20% impairment of a foot, leg, hand, arm, or the body as a whole?

HAVE YOU:

Yes	No	Participated in recreational drug use within the last year?
Yes	No	Participated in a drug abuse treatment program? Where?

ACCIDENTS & INJURIES

Please estimate the number of workdays you have lost in each of the past 2 years:

Please list the name of any doctors you have seen within the past two years. List your family doctor first.

Yes	No	Have you ever been hurt on the job or filed a workers' compensation claim in the past? If yes, how many times? In which years?

Please provide pertinent facts to every ailment or injury contributing to impairment, as well as all previous workers' compensation claims.

HAVE YOU EVER BEEN TREATED FOR:

Yes	No	Back pain	Yes	No	Neck pain
Yes	No	Hand pain	Yes	No	Mental conditions

HAVE YOU EVER BEEN REFUSED EMPLOYMENT/UNABLE TO HOLD A JOB BECAUSE OF:

Yes	No	Sensitivity to dust
Yes	No	Inability to perform certain motions
Yes	No	Inability to assume certain positions
Yes	No	Other medical reasons (please specify)

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AUTHORIZED SIGNATURE

OUR WORKERS' COMPENSATION INSURANCE CARRIER MAY CHECK FOR PREVIOUS CLAIMS BY NAME AND SOCIAL SECURITY NUMBER. IF YOU HAD A PREVIOUS CLAIM OR INJURY AND FAIL TO MAKE US AWARE OF IT, YOU MAY BE LEGALLY DENIED BENEFITS IN THE EVENT OF A NEW INJURY IN ACCORDANCE WITH THE LANDMARK RYCROFT RULING. FOR YOUR OWN PROTECTION AND IN ORDER TO SECURE APPROPRIATE MEDICAL CARE, PLEASE MAKE US AWARE OF ANY PREVIOUS INJURIES.

Signature:	Date:
Company Representative:	Date: