

CONDITIONAL JOB OFFER & MEDICAL REVIEW

Applicant note: This form is to be completed *only* after you have been given an offer of employment.

APPLICANT NAME _____

POSITION _____

DATE OF JOB OFFER _____

Based on qualifications presented on your application form and/or in your job interview, you are hereby offered a job with our organization conditional upon submitting to our standard medical review and the verification of your answers to the following questions. Your job offer cannot and will not be rescinded unless a medical review reveals that you cannot perform the essential functions of the job (with accommodations if requested), or you present a hazard to yourself or others. False or misleading statements are also grounds for rescinding this offer. Please note that workers' compensation benefits in some states may also be affected by false or misleading information. This form must be accurate and complete for us to process. This information is considered personal and medical in nature and will be treated as such by handling it confidentially in strict compliance with the Americans with Disabilities Act. This offer is valid only if the back of this page is signed by a company representative.

EMERGENCY INSTRUCTIONS

In case of emergency contact:

NAME _____

PHONE NUMBER _____

CITY/STATE _____

Are there any other emergency instructions, circumstances, medical needs, allergic responses or procedures the company should know?

(CONTINUE IN COMMENTS SECTION ON BACK IF NECESSARY)

HEALTH AND SAFETY

I. Yes No

Have you had any injury or injuries on the job?

If yes, please describe:

- a) date of injury
- b) employer
- c) body part affected
- d) cause
- e) amount of lost time
- f) any permanent disability (%)?
- g) was workers' comp. claim filed?

(If applying for a job in NY or IL, leave workers' comp. question, line g, blank)

1	2	3

Please list any others in comment section on the back

II. Yes No

Do you have or have you had other injuries or illnesses not on the job (home, auto, sports, hunting, etc.) that have resulted in hospitalization, surgery or lost work time?

If yes, please describe:

- a) date of injury/illness
- b) body part affected
- c) cause
- d) days in hospital
- e) days lost work time
- f) have you recovered?

1	2	3

Please list any others in comment section on the back

PERSONAL AND CONFIDENTIAL

THIS PAGE CONTAINS SENSITIVE INFORMATION, STORE IN SECURE "MEDICAL ONLY" FILES, SEPARATELY FROM PERSONNEL RECORDS!

III. Yes No

Are you taking any long term (more than 30 days) prescribed medication?

If yes, please describe:

- a) type of medication
- b) purpose
- c) side effects

1	2	3

IV. Yes No

Do you have or have you been diagnosed as having any illness or injury for which you are not seeking treatment?

If yes, please describe:

COMMENTS:

AFFIRMATION AND AUTHORIZATION:

I hereby affirm that the information on this form is true and correct, and that there are no omissions, false information or misrepresentation of facts. I authorize any physician, medical facility, law enforcement agency, administrator, state agency, institution, information service bureau, insurance company or employer contacted by this company or an agent of this company to furnish or verify workers' compensation information and medical records.

I further acknowledge that a telephone facsimile (FAX) or photographic copy shall be as valid as the original.

Today's Date Signature

Upon successful completion of this review you will be given a start date.

Today's Date Authorized Signature of Company Representative

FOR EMPLOYER USE ONLY

VERIFICATION (Personnel Administrator) _____

MEDICAL REVIEW (Medical Professional) _____

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