Post Offer Medical Questionnaire

Job Offeree: 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 questionnaire and any medical examination will be kept confidential and in separate files in compliance with the ADA. 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 (which will be job related and consistent with business necessity).

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.

Name: _____ Date of Birth: _____/_____/_____
Social Security Number: _____-____-_____ Height: _____ Weight: _____

Are you aware of any condition or injury that impairs or limits your ability to perform your position? ☐ No ☐ Yes:
Please Explain: _____
_____

Have you ever been refused employment because of your health? ☐ No ☐ Yes: Please Explain:_____
_____

Are you now, or have you ever been, treated for aches/pains of the back or neck? ☐ No ☐ Yes: Please Explain: _____
_____
When did you receive treatment, and by whom?_____ _____

Have you received medical treatment following a motor vehicle accident? ☐ No ☐ Yes: Please Explain: _____
_____
What treatment was received, and by whom: _____

Have you ever had any type of surgery? ☐ None ☐ Yes, list below (If additional space is needed please continue on back)
Surgery: _____ Body Part: _____ _____Year: _____by Doctor: _____
Surgery: _____ Body Part: _____ _____Year: _____by Doctor: _____

Have you ever had a workers' compensation injury? ☐ None ☐ Yes (If additional space is needed please continue on back of page)
Body part(s) injured: _____ Date of injury: _____ Employer: _____
Treating doctor: _____ Did you miss time from work? ☐ No ☐ Yes: How long? _____
Body part(s) injured: _____ Date of injury: _____ Employer: _____
Treating doctor: _____ Did you miss time from work? ☐ No ☐ Yes: How long? _____

Have you ever received a disability rating or had one assigned to you by an insurance company, medical professional, or state/federal agency? ☐ No ☐ Yes, Please Explain: _____

Is there any question you do not understand? ☐ No ☐ Yes Please Explain: _____

All statements and information provided are true to the best of my knowledge and belief. I understand that misrepresentations, as to pre-existing physical or mental conditions, may void any workers' compensation benefits.

Name of Offeree (print): _____ Date: _____

Signature: _____