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

PHONE: ☐ Home ☐ Cell ☐ Other | PHONE: ☐ Home ☐ Cell ☐ Other | EMAIL ADDRESS

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 our 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 Your job offer cannot and will not be rescinded unless a medical review reveals that you cannot perform the essential functions of the job (with accommodations if requested), or you present a hazard to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.

Who To Contact In Case of Emergency

NAME | RELATIONSHIP

CITY / STATE | PHONE NUMBER ( )

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

1. ☐ Yes ☐ No Have you had any injury or injuries on the job?

If yes, please describe:	1	2	3
a) date of injury			
b) employer			
c) body part affected			
d) cause			
e) amount of lost time			
f) any permanent disability (%)?			
g) was work comp claim filed?			

Please list any others in comment section on back.

2. ☐ 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:	1	2	3
a) date of injury			
b) employer			
c) body part affected			
d) cause			
e) amount of lost time			
f) any permanent disability (%)?			
g) was work comp claim filed?			

Please list any others in comment section on back.

Personal and Confidential

This page contains sensitive information. Store in secure "Medical Only" files, separately from Personnel Records!

3. ☐ Yes ☐ No Are you taking any long-term (more than 30 days) prescribed medication?

If yes, please describe:	1	2	3
a) type of medication			
b) purpose			
c) side effects			

4. ☐ 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.

SIGNATURE TODAY'S DATE

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

AUTHORIZED SIGNATURE OF COMPANY REPRESENTATIVE TODAY'S DATE

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