

Print Full Name \_\_\_\_\_ Date \_\_\_\_\_

Place check marks and dates in the appropriate individual boxes.

CONDITION: HAVE YOU EVER HAD OR ARE CURRENTLY HAVING DIFFICULTY WITH ANY OF THE FOLLOWING? (EXPLAIN IN DETAIL IF THE ANSWER IS YES.)	No	Yes	Date
1. Treatment, counseling or joined a group because of alcohol or drug abuse?			
2. Emotional/psychological disorder requiring medical treatment such as depression, anxiety, etc.			
3. Head injury, concussion, unconsciousness or bone fracture? If so, describe.			
4. Recurring headaches requiring prescription medication? If yes, list medication.			
5. Recurring dizziness, fainting spells, motion sickness or problems with balance?			
6. Epilepsy, convulsions, fits, seizures or any disorder of the nervous system?			
7. Cerebral vascular accident, stroke or ruptured aneurysm.			
8. Recurring shortness of breath, persistent hoarseness/cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, silicosis, asbestosis, tuberculosis or other chronic respiratory disorder or lung disease? If tuberculosis, when was your last TB test: Date: / / Positive <input type="checkbox"/> Negative <input type="checkbox"/>			
9. Eye disorder, color blindness, vision restrictions or injury? Partial loss of sight in one or both eyes? If so, state uncorrected vision.			
10. Corrective lenses? <input type="checkbox"/> Contacts <input type="checkbox"/> Glasses			
11. Chronic ear or sinus disorders?			
12. Hearing loss or deafness in either ear? If yes, has it been evaluated by a doctor or audiologist and does it require the use of a hearing aid?			
13. High blood pressure or hypertension? If yes do you require prescription medication or any type of diet restrictions?			
14. Jaundice, intestinal bleeding, ulcer, appendicitis, hepatitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestine, liver or gallbladder?			
15. Extremity problems, wrist disorders or hand gripping? (such as carpal tunnel syndrome, tendonitis, etc.)			
16. Tingling, numbness or pain in an arm, hand, leg or foot?			
17. Any medical problem that limits standing, walking, climbing or lifting?			
18. Back surgery or any disorder of the back including neck, mid and low back or any limitations in movement of the back?			
19. Treatment by a physician or chiropractor for a back, neck or muscle problems?			
20. Ruptured intervertebral disk (slipped disk or herniated disk), Spondylolisthesis (slipped vertebra) or Osteoporosis (bone loss)?			
21. Chronic osteomyelitis or bone infections?			
22. Muscle diseases such as muscular dystrophy (wasting of muscles)?			
23. Multiple sclerosis, cerebral palsy, polio or Parkinson's disease?			
24. Compressed air sequelae or the bends?			
25. Dermatitis, eczema, rashes or any skin disorder?			
26. Amputated or missing foot, leg, arm, hand, or finger?			
27. Thyroid or other gland disorders?			
28. Eating disorders?			
29. Any artificial apparatus? (Prosthesis, Pacemaker, etc.?)			
30. Arthritis, joint pain disease, ankyloses (fusing of joints), strength/muscular disorder/weakness, or bursitis? If so, did it require treatment by a medical care provider?			
31. Cancer, growth, blood marrow or lymph disorder. If yes, what body part? Any family history?			
32. Low or High blood sugar (diabetes and/or hypoglycemia)? If so, do you require medication or special dietary considerations?			
33. Sugar, albumin, blood or pus in urine, stone or other disorder of kidney or bladder?			
34. Anemia, blood disorder, family history of?			
35. Blood vessel or bleeding disorder? Varicose veins? Thrombophlebitis (blood clots), hemophilia?			
Remarks: (Reference the number you are answering. Use additional sheets of paper if necessary.)			
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CONDITION: HAVE YOU EVER HAD OR ARE CURRENTLY HAVING DIFFICULTY WITH ANY OF THE FOLLOWING? (EXPLAIN IN DETAIL IF THE ANSWER IS YES.)	No	Yes	Date
36. Heart disease, chest pains, angina, murmur, heart attack, arteriosclerosis or hardening of the arteries, or any heart trouble?			
37. Treated or diagnosed with Hepatitis A, B, or C?			
38. Immunizations: Tetanus <input type="checkbox"/> YES <input type="checkbox"/> NO Date: _____			
39. Do you smoke? (Packs per day? _____)			
40. Allergies or drug sensitivities?			
41. Hernia or "rupture"? Did it require surgical repair?			
42. Treatment for <u>any</u> medical condition at this time or have any condition not previously noted? (List on page 3 all prescribed as well as over the counter medications taken).			
43. Told that you should have any kind of operation that you never had?			
44. Assigned any type of permanent work restrictions (i.e.) lifting, bending, climbing etc?			
45. Any disability that requires special accommodations to perform the tasks of the job for which you were hired as you understand them?			
46. Ever received a Disability rating for any medical condition? If yes what body part and what was the % of that rating?			
47. Received medical treatment for exposure to a chemical or physical agent (i.e., heat/cold, stress, vibrations, noise, etc.)?			
48. Sensitive to chemicals, paints, solvents, dust, sunlight, oils, hydrocarbons, or detergents?			
49. Sensitive to working outdoors, including extreme cold weather?			
50. Exposed to the manufacture of pesticides, paints, explosives or dye?			
51. Heavy metal poisoning or ionizing radiation injury?			
52. Any involvement in an asbestos or lead abatement project?			

Condition: THE FOLLOWING QUESTIONS REVIEW YOUR PRESENT AND PAST ABILITIES TO PERFORM CERTAIN FUNCTIONS OF THE JOB WHICH YOU HAVE APPLIED FOR. HAVE YOU EVER HAD OR ARE CURRENTLY HAVING DIFFICULTY WITH ANY OF THE FOLLOWING? (EXPLAIN IN DETAIL IF THE ANSWER IS YES.)	No	Yes
53. Routinely lifting 55 pounds from the floor to the waist? If yes, what weight?		
54. Routinely lifting 25 pounds overhead? If yes, what weight?		
55. Routinely pushing/pulling 55 pounds? If yes, what weight?		
56. Running/jogging fast for 75-100 yards?		
57. Climbing up to 30 stairs?		
58. Standing without a break for a 20 minute interval or intermittently for up to four hours?		
59. Kneeling/squatting/stooping/crouching intermittently for up to 2 hrs? Sitting intermittently for up to 4 hrs?		
60. Are you right handed or left handed? <input type="checkbox"/> Right <input type="checkbox"/> Left Do you have difficulty or have you had difficulty using both arms simultaneously?		
61. Gripping, seizing or working with either one or both hands?		
62. Pinching, picking up, performing fine motor skills, with fingers of both hands?		
63. Feeling or interpreting object size, shape and temperature with hands?		
64. Giving spoken instruction clearly and quickly?		
65. Hearing and understanding spoken instruction clearly and quickly?		
66. Any driving restrictions?		
67. Problems with heights i.e. climbing ladders up to 50 feet?		
68. Problems with confined spaces i.e. claustrophobia?		
69. Problems tasting/smelling or distinguishing different odors easily and accurately?		
70. Problems with shift work or sleeping disorders?		
71. Have you ever received vocational rehabilitation services or benefits because you were told by a physician you could not engage in this type of work?		

Remarks: (Reference the number you are answering. Use additional sheets of paper if necessary.)

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### AUTHORIZATION

I certify that the information given by me in this Questionnaire is true in all respects. I warrant that I am physically and mentally fit to perform the essential duties that are/will be required of me either with or without reasonable accommodation in the position occupied. I understand that my physical and mental ability to perform my job will be determined in substantial part by the responses I have made to this questionnaire.

\_\_\_\_\_  
(initial)

I recognize that any falsification or misrepresentation (including any omissions) made by me in connection with filling out this form, my physical examination and medical history may subject me to discharge from employment without notice and I may not be entitled to workers compensation benefits if I should sustain an on-the-job injury. *\*SEE BELOW\**

\_\_\_\_\_  
(initial)

If I answered affirmatively that I have or have had one of the conditions or exposure I listed in the health questionnaire, I hereby authorize any medical doctor or hospital to release details regarding that condition or exposure to the Company or its representative or agent. I hereby release any medical doctor or hospital from any and all liability as a result of providing the above-mentioned information. This release, and all authority to disclose information pertaining to me, shall remain in affect through the duration of my employment or throughout the duration of any claim made by me as a result of any on-the-job injury. I understand the results of the medical examination (post offer) and medical information are confidential and will be maintained in accordance with applicable law by my employer or its designated representative. I agree to take any applicable medical examination (post offer) required by law or by the Company as related to employment.

\_\_\_\_\_  
(initial)

**I fully understand and agree to comply with all conditions and provisions outlined above.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

If at any time your health history changes such that it would also change an answer to any of the questions in this questionnaire, you must advise your safety representative of this by your next scheduled work day so that your health and the safety of the work environment can be respected. This includes, but is not limited to, any change in prescribed medications or over-the-counter medications.

**\*\*Alaska Worker's Compensation Act Sec 23.30.022 False Statements By An Employee\*\***

An employee who knowingly makes a false statement in writing as to the employee's physical condition in response to a medical inquiry, or in a medical examination, after a conditional offer of employment may not receive benefits under this chapter if:

1. The employer relied upon the false representation and this reliance was a substantial factor in hiring; and
2. There was a causal connection between the false representation and the injury to the employee.