On-Site Health & Safety

520 6th Street, Rodeo, CA 94572
Phone (866) 998-2750

Form 01: Health Screening Questionnaire

Based on qualifications presented in your application form and/or in your job interview, you have been offered employment with our organization conditional upon completing our standard medical review and the verification of your answers to the following questions. Your employment offer cannot and will not be rescinded unless a medical review indicates that you cannot perform the essential functions of the job (with reasonable accommodation, if requested), you present a hazard to yourself or others, or you provide false, misleading or inaccurate statements.

By signing this form, you hereby authorize the use and disclosure of your individually identifiable testing and medical information, which could otherwise be deemed "protected health information" under the Health Insurance Portability and Accountability Act. Any information requested in this form is pursuant to my prospective employer's policy.

Signature: _____ **Date:** _____

Name: (Last, First, Middle Initial):		**Male: ____ Female: ____**	**Date of Birth:**
Position Applying For:			
Social Security No. (Last 4 Digits):		**Drivers License or ID No. :**	
Phone Number:	**State:**	**Exp. Date:**	**Class:**
Address:		**Company Name:**	

Place an "X" in the appropriate boxes below. Please mark every item either "Yes" or "No". For any "Yes" answers, please explain in the Remarks section below. Do you have, or have you ever been diagnosed with any of the following:

Yes	No		Yes	No	
		Epilepsy, seizures or "fits"			**Back or neck injury or surgery**
		Hernia			**Head injury or brain damage**
		Cardiac (Heart) Disease			**Eye problems (except corrective lenses)**
		Arthritis			**Fainting or dizziness**
		Silicosis, asbestosis or other cancer			**Breathing problems**
		Hemophilia			**Shoulder, elbow or wrist problems including carpal tunnel**
		Heavy metal poisoning			**Knee disorders or surgery**
		Diabetes			**Kidney or Liver disease**
Remarks for "Yes" answers. If you need more space, please use the back of this form.					

Print Name: _____

Place an "X" in the appropriate boxes below. Please mark every item either "Yes" or "No". For any "Yes" answers, please explain in the Remarks section below.

Yes	No	
		Have you ever had back problems?
		Have you ever been hospitalized, treated or counseled for use of alcohol or drugs?
		Have you ever had surgery, or are you contemplating surgery in the future?
		Have you ever been refused employment for medical reasons?
		Have you ever suffered a loss of consciousness?
		Have you ever had any work-related injury or illness?
		Have you ever had any injuries not mentioned on this form?
		Have you been diagnosed with muscular disease
		Do you have an open workers' compensation claim?
		Do you take medication that can interfere with your ability to drive or to operate machinery?
Remarks for "Yes" answers. If you need more space, please use the back of this form.		

CERTIFICATION, AFFIRMATION AND AUTHORIZATION:

I, _____ certify that I am physically able to perform the above duties, and that I am not taking any medications, nor do I have any known injuries, which would impair my ability to perform my job duties safely.

Signature: _____ **Date:** _____

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To be filled out by technician:

☐ DRUG SCREEN COMPLETED ☐ NEGATIVE ☐ SENT TO LAB FOR FURTHER TESTING
☐ MEETS FIELD CRITERIA - OK TO PROCESS WITH FORM 02
☐ DOES NOT MEET FIELD CRITERIA (MANDATORY CALL IN)

TECHNICIAN NOTES:

Technician Name: _____ **Date:** _____

Technician Signature: _____ **Run #:** _____