

Please bring this completed form with you to your pre-employment health assessment with an Team Member Health Staff Member.

Applicant Name:		
First	MI	Last
Street Address:		
City:	State:	Zip:
Home Phone Number:	Alternate Phone Number: Type: <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Other	
Date of Birth: (Month/Day/Year)	Social Security Number:	
Position Offered:	Department/Unit:	
Previously Worked at This Organization? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when/where?		
Emergency Contact Name:	Relationship to you:	
Emergency Contact Phone Number: Type: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Other	Alternate Phone Number: Type: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Other	

Employment with North Memorial Health Care is conditional upon the successful completion of the health history review and its approval by a Team Member Health Nurse. Please answer the questions carefully and completely. This information will not be shared with your supervisor unless it has implication for work restrictions or your safety. Omission or misrepresentation of the information requested can be sufficient case, in and of itself, for termination of employment whenever discovered.

Please respond "YES" or "NO" to the questions asked. If "YES", please describe. **Answer the questions only as they apply to the essential functions of the position you have been offered.**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>1. Do you have concerns regarding your ability to perform the physical or mental requirements of the job? If "YES", describe the concerns:</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>2. Do you have medical restrictions, or self-imposed limitations, regarding your ability to perform the essential functions of the job? If "YES", describe the restrictions/limitations:</p> <p>2a. If you answered "YES" to question 2, what accommodations, in your opinion, would allow you to do the essential functions of the job?</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>3. Do you have any allergies or sensitivities (including, but not limited to, dermatitis, dust, pets, soap, rubber/latex, smoke, plants, fragrances) that might interfere with your ability to do the essential functions of the job? If "YES", please list:</p>

<p>4. Do you have restrictions or limitations in your ability to perform any of the following activities as they relate to the essential functions of your job?</p> <table border="1"> <thead> <tr> <th>YES</th> <th>NO</th> <th></th> <th>YES</th> <th>NO</th> <th></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Standing</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Lifting</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Walking</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Pushing</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Sitting</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Pulling</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Bending</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Repetitive Motions</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Squatting</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Reaching</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Number of Hours Worked/Shift</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Balancing (concerns related to dizzy spells or fainting)</td> </tr> </tbody> </table> <p>If "YES" to any of the above, please explain:</p>					YES	NO		YES	NO		<input type="checkbox"/>	<input type="checkbox"/>	Standing	<input type="checkbox"/>	<input type="checkbox"/>	Lifting	<input type="checkbox"/>	<input type="checkbox"/>	Walking	<input type="checkbox"/>	<input type="checkbox"/>	Pushing	<input type="checkbox"/>	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	Pulling	<input type="checkbox"/>	<input type="checkbox"/>	Bending	<input type="checkbox"/>	<input type="checkbox"/>	Repetitive Motions	<input type="checkbox"/>	<input type="checkbox"/>	Squatting	<input type="checkbox"/>	<input type="checkbox"/>	Reaching	<input type="checkbox"/>	<input type="checkbox"/>	Number of Hours Worked/Shift	<input type="checkbox"/>	<input type="checkbox"/>	Balancing (concerns related to dizzy spells or fainting)
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>5. As it relates to the essential functions of the job you have been offered, do you have any musculoskeletal issues (bones, joints, muscles, ligaments, cartilage, tendons, bursa, disc etc.) or pain that involves periodic flare-ups or periodic ongoing treatment (medical treatment or home remedies)? If "YES", please explain:</p>																																													
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>6. Is there anything else you feel we should know about you to better promote your safety or patients' safety while at work? If "YES", please explain:</p>																																													

- A urine drug screen will be collected at the time of your pre-placement exam. Please bring a photo ID with you, and do not eat anything with poppy seeds for 2-3 days before your appointment.
- Please bring the following information with you to your appointment, or you can have it faxed to us at 763-581-2181:
 - Immunization records including:
 - MMR (measles, mumps, rubella)
 - Hepatitis B vaccine series
 - Varicella vaccine (chicken pox history)
 - Tdap/ Tetanus booster
 - Mantoux (tuberculosis testing)

I have reviewed the defined physical and mental requirements for the position I have been offered. I certify that my answers to the questions on this form are true, correct and complete to the best of my knowledge and belief.

If completed electronically, please print the completed form and sign in ink.

Applicant Signature	Date

For Team Member Health Use Only – Reviewed by:

Team Member Health Nurse Name and Signature	Date