POST-OFFER-OF-EMPLOYMENT MEDICAL INQUIRY

Completion of this report is requested to assist your employer with the claims management process.

Name_____ Department_____ Position_____

To the best of your knowledge do you have or have had any of the following medical problems?

Answer YES or NO

_____ 1. **Epilepsy**
_____ 2. **Diabetes**
_____ 3. **Arthritis**
_____ 4. **Amputated foot, leg, arm or hand**
_____ 5. **Loss of sight** of one or both eyes or a partial loss of uncorrected vision of more than 75% bilaterally
_____ 6. **Residual disability from Poliomyelitis**
_____ 7. **Cerebral palsy**
_____ 8. **Multiple sclerosis**
_____ 9. **Parkinson's disease**
_____10. **Cardiovascular disorders**
_____11. **Tuberculosis**
_____12. **Mental retardation**, provided the employee's intelligence quotient is such that he falls within the lowest 2% of the general population; provided, however, that it shall not be necessary for the employer to know the employee's actual intelligence quotient of the general population
_____13. **Psychoneurotic disability** following confinement for treatment in a recognized medical or mental institution for a period in excess of six months
_____14. **Hemophilia**
_____15. **Sickle cell anemia**
_____16. **Chronic osteomyelitis**
_____17. **Ankylosis** of major weight bearing joints
_____18. **Hyperinsulism**
_____19. **Muscular dystrophy**
_____20. **Total occupational loss of hearing** as defined in Code 34-9-264
_____21. **Compressed air sequelas**
_____22. **Ruptured intervertebral disc**
_____23. **Back conditions** (Identify below)
__ a. back surgery
__ b. degenerative disc disease
__ c. multiple back strains
__ d. chronic back pain
__ e. other (explain)
_____24. **Neck conditions** (Identify below)
__ a. neck surgery
__ b. degenerative disc disease
__ c. multiple neck strains
__ d. chronic neck pain
__ e. other (explain)
_____25. **Knee conditions** (Identify below)
__ a. left knee surgery
__ b. right knee surgery
__ c. other (explain)
_____26. **Hip replacement surgery**
_____27. **Any permanent condition that has been rated by a doctor as 20%, or more, impairment to the foot, leg, hand, arm, or to the body as a whole**
_____28. **Any other chronic medical condition or pre-existing disease (explain below)**

For "yes" responses indicate the nature of injury or illness and name of physician in Remarks.

Remarks_____

_____

Employee Signature_____ Date_____

Employer Signature_____ Date_____