Danbury Township Pre-Employment Health Questionnaire

The purpose of this questionnaire is to determine whether you can meet the requirements of the job for which you are applying. If you are hired, this information will remain a permanent, confidential record in your personnel file and is not subject to disclosure during public records requests. Should you not be hired, this document will be destroyed.

Name :_______________________________________ Date of birth: ___________

Street address:________________________________ City: __________________

State: _________ Zip: ____________ Phone: ____________________________

Name, address and phone of your personal physician: _________________________

____

Complete all of the following questions

Have you read the description of the position for which you are applying? Yes ___ No ___

If "no", do not complete this questionnaire until you have read the job description.

As it relates to the job and the contents of the job description, are there any health-related conditions (physical, mental or medical including, but not limited to disease, disorder, defect, handicap, disability, deformity, abnormality or any other condition including alcoholism or drug use or dependency) which would prevent you from performing the duties outlined in the job description? Yes____ No____

If yes, specify exactly why you could not perform the duties: ____________________

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Are you taking any medications including over the counter drugs? Yes____ No____

If yes, specify each medication, its dosage and frequency of taking: _______________

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Do you take any medications while at work or before work which, according to the manufacturer, could affect your physical or mental function or performance?

Yes____ No_____

If yes, explain: ____

____

In the last five years have you had an illness or injury which caused you to be absent from work or school for more than one week? Yes ___ No ___

If yes, explain:____

____

Have you received treatment for any medical condition or injury in the last 12 months that requires you to be under the current care of any healthcare provider? Yes ___ No ___

If yes, explain:____

Have you ever filed a workers' compensation claim because of a job-related injury?

Yes ___ No ___

If yes, provide date(s) and type(s) of injury and employer(s) name and address:

____

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Do you currently use tobacco, nicotine, vaping or similar products? Yes ___ No ___

Do you drink alcoholic beverages? Yes ___ No ___

If yes, how many drinks in a day _____ and how many days a week ____.

Have you ever had any reactions to chemicals for which you sought medical attention?

Yes ___ No ___

If yes, explain:____

Have you ever been forced to give up a job for health reasons? Yes ___ No___

If yes, explain: ____

____

Have you ever been refused a driver's license due to your health? Yes ___ No___

If yes, explain: ____

Do you have a sensitivity or allergy to latex? Yes ___ No ___

Do you have any food or drug allergies? Yes ___ No ___ If yes, explain: ____________

____

Describe your present state of health:

Excellent ___ Good ___ Fair ___ Poor ___

How many pounds can you lift comfortably without help? ______________________

When did you last have a physical exam?_______________________________________

You must provide the results of this exam to the Danbury Township Assistant Fiscal Officer within 10 (ten) business days of today's date. The results of this exam will be a major factor in the determination of whether you will be hired.

Initial here to acknowledge the above paragraph: ____________

Do you have:

Sensitivity to chemicals, dust or sunlight? Yes ___ No ___

Inability to perform certain motions? Yes ___ No ___

Inability to assume certain positions? Yes ___ No ___

Other medical, emotional or physical issues? Yes ___ No ___

If you answered "Yes" to any of the above, please explain in detail:__________________

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Do you have health issues that make you susceptible to indoor air quality issues such as:

Allergies: Yes ___ No ___ Chronic Respiratory Disease: Yes ___ No ___

Asthma: Yes ___ No ___ Cardiovascular Disease: Yes ___ No ___

Migraines: Yes ___ No ___ Other chronic illnesses, chemo, etc.: Yes ___ No ___

If yes, provide detailed information: ____

____

____

Do you have any chronic or recurring pain, limited motion or numbness associated with your neck, back, arms, wrists, hands or elsewhere? Yes ___ No ___

If yes, provide detailed information: ____

____

____

Have you been vaccinated for the following:

Rubella (German Measles): Yes ___ No ___ Don't know ___

Rubeola (Measles): Yes ___ No ___ Don't know ___

Varicella (Chicken Pox): Yes ___ No ___ Don't know ___

Hepatitis B: Yes ___ No ___ Don't know ___

Tetanus/T-dap: Yes ___ No ___ Don't know ___

All employees must be tested for Tuberculosis as a condition of employment. If you are previously positive, a chest x-ray will be ordered unless you can present a copy of a negative chest x-ray done within the past three years.

Place a checkmark in front of each condition you currently have or previously experienced. Only provide information about yourself. DO NOT provide any family or genetic history.

__ Positive TB skin test	__ Concussion	__ Hearing loss
__ Tuberculosis	__ Head injury	__ Hearing pain or throbbing
__ Chicken pox or Shingles	__ Brain trauma	__ Anemia
__ Hepatitis	__ Serious accident	__ Bleeding disorder/clots
__ Physical disability	__ Cholesterol issues	__ Recent weight changes
__ Loss of limb	__ Arthritis	__ Frequent indigestion
__ Fractures/broken bones	__ Back issues	__ Peptic ulcer
__ Angina	__ Herniated disc	__ Intestinal disease
__ Chest discomfort	__ Pulled muscles	__ Liver disease
__ Rheumatic fever	__ Strains	__ Kidney disease/stones
__ Heart disease	__ Numbness	__ Gallbladder issues/stones
__ Heart attack	__ Carpal Tunnel	__ Depression/excess worry
__ Heart murmur	__ Disc removal/repair	__ Drug/alcohol dependency
__ Irregular heart rate	__ Spinal fusion	__ Panic disorder/anxiety
__ Mitral valve prolapsed	__ Asthma/lung diseases	__ Color blindness
__ High blood pressure	__ Broken ribs	__ Convulsions
__ Stroke	__ Chronic bronchitis	__ General weakness/fatigue
__ Fainting or dizziness	__ Collapsed lung	__ Vision problems
__ Seizures/Epilepsy	__ Coughing up blood	__ Hernia/rupture
__ Severe headaches	__ Emphysema	__ Cancer/tumor
__ Diabetes	__ Shortness of breath	__ Anything else not listed
__ Thyroid problems	__ Wheezing	

Use this page to explain each issue you have checked:

List any surgeries you have had: ____

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I understand this questionnaire, any lab tests and/or any diagnostic testing ordered is strictly for evaluation of my fitness for duty for this position. The results will be used to ensure I am able to safely perform the functions for the position I may be offered.

I understand this information is confidential and is not subject to public records requests.

I understand if I am not hired this questionnaire will be destroyed.

I understand I may be required to provide additional medical information and/or undergo further medical evaluation prior to being hired.

I understand the discovery of any misrepresentation or false information on this questionnaire will be grounds for withdrawal of any offer of employment and, if hired, grounds for termination.

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Printed name of applicant

____________________________________ ______________________________

Signature of applicant Date signed