JOYBRINGERS

JOB PLACEMENT/MEDICAL HISTORY QUESTIONNAIRE

Name: ____ SS#:____________________________________

Home health care is a physically demanding job that might require you to bend, carry, lift and perform a client transfer or similar activity related to the care of our adult and pediatric clients. To keep you and our clients safe, we need your help. Please answer the questions listed below.

The information you provide will be used to assist Joy Bringers Home Care (JBHC) in making appropriate assignments. A "no" response will not automatically disqualify or exclude you from a position with JBHC. Reasonable accommodations may be made to support your employment.

Bend (on and off for 1 hour)
( ) Yes, I can do this activity without limitation or restriction.
( ) I can do this activity with the following restriction ____.
( ) No, I cannot perform this activity.

Carry (up to 35 lbs. - equal to 4 gallons of water)
( ) Yes, I can do this activity without limitation or restriction.
( ) I can do this activity with the following restriction ____.
( ) No, I cannot perform this activity.

Lift (up to 35 lbs. - equal to 4 gallons of water)
( ) Yes, I can do this activity without limitation or restriction.
( ) I can do this activity with the following restriction ____.
( ) No, I cannot perform this activity.

Client Transfer (with client or third party assistance - Adults: 100-150 lbs., Children: 50-100 lbs.)
( ) Yes, I can do this activity without limitation or restriction.
( ) I can do this activity with the following restriction ____.
( ) No, I cannot perform this activity.

Push/Pull (up to 60 lbs. of force - equal to pushing a fully loaded grocery cart)
( ) Yes, I can do this activity without limitation or restriction.
( ) I can do this activity with the following restriction ____.
( ) No, I cannot perform this activity.

Twist (on and off for 1 hour)
( ) Yes, I can do this activity without limitation or restriction.
( ) I can do this activity with the following restriction ____.
( ) No, I cannot perform this activity.

Please provide more information if any of your limitations or restrictions are temporary so we are aware of follow-up actions needed.

PLEASE TURN OVER FOR SIDE 2

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Do you have any other medical conditions that could potentially affect your ability to perform your **essential job duties**? The information you provide will be used to assist Joy Bringers Home Care in making appropriate assignments. A "yes" response will not automatically disqualify or exclude you from a position with JBHC. Reasonable accommodations may be made to support your employment.

	YES	NO
A. Arthritis, back pain, gout or any other disease of the back, spine, neck, bones, muscles or joints.	( )	( )

Explain: ______________________________

B. Surgical operations within the past 10 years?	( )	( )

Explain (indicate Month/Year.): ______________________________

C. Any accidents or injuries within the last 5 years?	( )	( )

Explain (indicate Month/Year): ______________________________

D. Exposure to tuberculosis, hepatitis, or any other infectious disease.	( )	( )

Explain (indicate Month/Year): ______________________________

E. Current use of heroin, cocaine, crack, hallucinogens, tranquilizers, barbiturates, amphetamines or other medications that are not prescribed by a duly licensed physician/practitioner.	( )	( )

Explain: ______________________________

F. Psychiatric condition or mental illness that could impact your ability to work independently with limited supervision.	( )	( )

Explain: ______________________________

G. Do you have any other medical condition that could restrict your ability to work in home health care?	( )	( )

Explain: ______________________________

In the event of an emergency, Joy Bringers Home Care should contact:

Name	Relation	Phone

I hereby certify that I have provided Joy Bringers Home Care with true and complete medical information, including items specific to my ability to perform this job. I understand and agree that this information will used to assist with work assignments and will be released to medical providers in the event of a work related injury or medical emergency. I will promptly notify JBHC with any updates/changes to my medical and functional information. I recognize that my failure to provide complete and truthful information may result in termination.

In the event of an emergency, I authorize JBHC to share this information with medical personnel.

Signature: ______________________________ Date: ______________

Reviewed by: ______________________________ Date: ______________
Director Signature/Title