M D MEDICAL CLINICS
Occupational Services

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Medical Director

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NAME: _____ DATE: _____

HAVE YOU HAD ANY HISTORY OF:

1. BACK ACHES	[ ] Yes	[ ] No
2. BACK INJURIES	[ ] Yes	[ ] No
3. BACK PROBLEMS	[ ] Yes	[ ] No
4. NECK INJURIES	[ ] Yes	[ ] No
5. KNEE INJURIES	[ ] Yes	[ ] No

TO ALL PROSPECTIVE EMPLOYEES:

The pre-placement physical you will receive should in no way be interpreted by you as being a complete physical examination. This is only a screening test to determine certain conditions which would result in the inability to perform certain job duties.

If you pass this test, it does not necessarily mean that you are in good health. You should still have a regular physical examination.

I understand that all screening test results and evaluations will not be considered confidential medical information by the medical department, and may be discusses with and/or made available to COMPANY MANAGEMENT.

NAME OF FAMILY DOCTOR, IF ANY: _____

DATE OF LAST PHYSICAL EXAMINATION: _____

IF YOU FULLY UNDERSTAND AND CONSENT TO THE ABOVE, PLEASE SIGN AND DATE BELOW:

_____ _____
Date Signature

"Keeping You on Your Job is Our Job"