CONDITIONAL JOB OFFER
PERSONAL & CONFIDENTIAL

Applicant note: This form is to be completed only after you have been given an offer of employment. This form will be kept in a secure "medical only" file at the Home Office.

Manager's note: Do not duplicate this form. Send directly to Home Office.

Applicant Name	Position	Date of Job Offer

Based on qualifications presented on your application form and/or in your job interview, you are hereby offered a job with our organization conditional upon:

1. Submission and evaluation of a medical drug / alcohol test
2. Evaluation of your police record

False or misleading statements are also grounds for rescinding this conditional job offer or termination of employment after hire. This form must be accurate and complete for us to process. This information is considered personal and medical in nature and will be treated as such by handling it confidentially in strict compliance with the Americans with Disabilities Act. This offer is only valid when signed by a company representative.

MEDICAL REVIEW:

In case of an emergency contact:

Name	Phone Number
Relationship	City / State

Are there any other emergency instructions, circumstances, medical needs, allergic responses or procedures that you wish the company to know?

MEDICAL REVIEW CONTINUED…
Health & Safety

☐ Yes ☐ No Have you had any injury or injuries on the body?

If yes, please describe:

	1	2	3
Date of Injury			
Employer			
Body part affected			
Cause			
Amount of lost time			
Any permanent disability (%)?			
Was workers comp claim filed?			

Please list any others on back

☐ Yes ☐ No Do you have or have you had other injuries or illnesses not on the job (home, auto, sports, hunting, etc.) that have resulted in hospitalization, surgery, or lost work time?

If yes, please describe:

	1	2	3
Date of injury / illness			
Body part affected			
Cause			
Days in hospital			
Days lost work time			
Have you recovered?			

Please list any others on back

☐ Yes ☐ No Are you taking any long term (more than 30 days)prescribed medications?

If yes, please describe:

	1	2	3
Type of medication			
Purpose			
Side effects			

MEDICAL REVIEW CONTINUED…

☐ Yes ☐ No Do you have or have you been diagnosed as having any illness or injury for which you are not seeking treatment?

If yes, please describe:

_____

_____

_____

Comments: _____

_____

_____

_____

_____

_____

AFFIRMATION & AUTHORIZATION

I hereby affirm that the information on this form is true and correct, and that there are no omissions. I authorize any physician, medical facility, law enforcement agency, administrator, state agency, institution, information service bureau, insurance company or employer contacted by this company or any agent of this company to furnish or verify workers compensation information an medical records.

I further acknowledge that a telephone facsimile (fax) or photographic copy of this form shall be valid as the original.

I also acknowledge that I have received a copy of the following personnel and safety policies:

1. Job Description
2. Personnel Policies (vacation, sick, medical, leave, etc.)
3. Workplace Safety Program (Assignment of Responsibilities, Safety Requirements and Procedures, Safety Rules, Drug/Alcohol Policy)

I also certify that I have received instructions on all Safety Rules and procedures including but not limited to the following

- Safety techniques used to avoid injuries for the equipment I am authorized to use;
- The purpose and location of MSDS sheets; and,
- Chemical labeling

I also certify that I have received safety glasses, leather gloves, and a safety belt supplied free of charge by the company.

Signature _____ Date _____

Manager's note: Copy only page 4 of this form and file in the Training Section of the Workplace Safety Program. Return the original, completed form, to the Personnel Office.