# PERSONAL AND CONFIDENTIAL

# PARKING COMPANY OF AMERICA

**Note to Applicant:** **This form is to be completed only when the first section is completed and signed by an authorized representative of our Company.**

## CONDITIONAL JOB OFFER & MEDICAL HISTORY

_____ _____ ☐ Telephone ☐ In Person

APPLICANT NAME DATE OF JOB OFFER

_____ OFFER EXPIRES: _____

JOB/POSITION OFFER Time Date

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 resubmitting to our standard medical review and the verification of your answers to the following questions. Your job offer cannot and will not be rescinded unless a medical review reveals that you cannot perform the essential functions of the job, or you present a hazard to yourself or others. False or misleading statements are grounds for termination of this offer or your 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 confidentially at all times in strict compliance with the Americans with Disabilities Act. This offer is only valid when signed by an authorized company representative below.

**THIS FORM SHOULD BE RETURNED BY 5:00 P.M. ON _____.**

Authorized Company Signature: _____ Date: _____

**EMPLOYMENT ELIGIBILITY** You MUST be able to produce documentation showing that you are legally eligible to work in the United States of America. On your first day of employment, be prepared to produce one piece of photo identification which establishes your identity, as well as one piece of documentation which establishes your employment eligibility.

**EMERGENCY INSTRUCTIONS**

In case of emergency, contact: _____ _____

Name Phone Number

_____ _____

Relationship City/State

Are there any emergency instructions, circumstances, medical needs, allergic responses or procedures the Company should know regarding your physical condition? _____

_____

**HEALTH AND SAFETY**

☐ Yes ☐ No Have you had any injuries or illnesses on the job? If yes, please list all (attach additional sheets if necessary).

| | 1 | 2 | 3 |
|---|---|---|---|
| • date of injury | _____ | _____ | _____ |
| • employer | _____ | _____ | _____ |
| • body part affected | _____ | _____ | _____ |
| • cause | _____ | _____ | _____ |
| • amount of lost time | _____ | _____ | _____ |
| • any permanent disability (%)? | _____ | _____ | _____ |
| • was Workers Comp claim filed? | _____ | _____ | _____ |

**JOB RELATED**

Can you lift up to 50 lbs.? ☐ **Yes** ☐ **No**

Are you restricted from lifting? ☐ **Yes** ☐ **No**

Are you restricted from sitting or standing for extended periods of time? ☐ **Yes** ☐ **No**

## PAST MEDICAL HISTORY

I am now or have been treated for the following physical disabilities:

| | | | | | |
|---|---|---|---|---|---|
| Allergy, asthma, wheezing, or shortness of breath | ☐ Yes | ☐ No | Arterio-Sclerosis | ☐ Yes | ☐ No |
| Head or spinal injuries | ☐ Yes | ☐ No | Thrombo-phlebitis | ☐ Yes | ☐ No |
| Cardiovascular disease or heart ailment or condition | ☐ Yes | ☐ No | Chronic Ostemyelitis | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No | Ankylosis of Joints | ☐ Yes | ☐ No |
| Epilepsy | ☐ Yes | ☐ No | Amputations | ☐ Yes | ☐ No |
| Hearing Difficulties | ☐ Yes | ☐ No | Poliomyelitis | ☐ Yes | ☐ No |
| Multiple Sclerosis | ☐ Yes | ☐ No | Cerebral Vascular Accident | ☐ Yes | ☐ No |
| Convulsions, seizures, fits or fainting | ☐ Yes | ☐ No | Parkinson's Disease | ☐ Yes | ☐ No |
| Migraine headaches | ☐ Yes | ☐ No | Cerebral Palsy | ☐ Yes | ☐ No |
| Hemophilia | ☐ Yes | ☐ No | Loss of sight or partial loss/ vision problems | ☐ Yes | ☐ No |
| Tuberculosis | ☐ Yes | ☐ No | Hernia | ☐ Yes | ☐ No |
| Muscular Dystrophies | ☐ Yes | ☐ No | Silicosis | ☐ Yes | ☐ No |
| High or Low blood pressure | ☐ Yes | ☐ No | Obesity | ☐ Yes | ☐ No |
| Varicose Veins | ☐ Yes | ☐ No | Arthritis | ☐ Yes | ☐ No |
| Psycho-neurotic Disability | ☐ Yes | ☐ No | Ulcers | ☐ Yes | ☐ No |
| Do you smoke? | ☐ Yes | ☐ No | Extensive confinement by illness or injury | ☐ Yes | ☐ No |
| Are you pregnant now? | ☐ Yes | ☐ No | | | |

If you answered YES to any of the above questions, please explain below:

_____

_____

☐ **Yes** ☐ **No** Is there a condition that you are being treated for but is not listed? If yes, please describe:

_____

☐ **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:

_____

☐ **Yes** ☐ **No** Are you currently taking or have you taken within the past six months any medication prescribed by a doctor? If YES, please describe:

| | 1 | 2 | 3 |
|---|---|---|---|
| • type of medication | _____ | _____ | _____ |
| • purpose | _____ | _____ | _____ |
| • side effects | _____ | _____ | _____ |

## COMMENTS

_____

_____

_____

## AFFIRMATION AND 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 an agent of this Company to furnish or verify Workers Compensation information and medical records. I further acknowledge that a telephone facsimile (FAX) or photographic copy of my signature below shall be as valid as the original.

_____ _____

SIGNATURE DATE

**PERSONAL AND CONFIDENTIAL – store in secure "MEDICAL ONLY" files**