

MEDICAL AND PHYSICAL EXAMINATION PROGRAM (MAPEP)

Health Information Checklist

This checklist contains questions regarding your medical history and health. The primary use of this information will be to alert the employer and applicant of conditions that could negatively impact the health of customers or co-workers. This information may be used to determine fitness to perform job duties. This information will be handled in a confidential manner. It is essential that you answer all questions truthfully and completely. False or incomplete information may result in disqualification or termination if hired.

Completed by Applicant/Employee

(Type or Print in Ink)

Date: _____

Employee Name: (Last, First, Middle): _____

Employing Agency: Lookout Mountain Community Services Date Employed: _____

Have you now, or ever had the following?

	Yes	No
1. Loss of sight of both eyes. Loss of uncorrected (without glasses or contact lens) vision of more than 75% bilaterally (vision of 20/160 or J* or worse using both eyes).	<input type="checkbox"/>	<input type="checkbox"/>
2. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
3. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
4. Epilepsy (convulsions, seizures or fits)	<input type="checkbox"/>	<input type="checkbox"/>
5. Ankylosis (immobility) of major weight bearing joints (ankles, knee, hip)	<input type="checkbox"/>	<input type="checkbox"/>
6. Any permanent condition which causes 20% (or more) impairment of a foot, leg, hand, arm, back, or the body as a whole	<input type="checkbox"/>	<input type="checkbox"/>
7. Arthritis which is a hindrance to employment	<input type="checkbox"/>	<input type="checkbox"/>
9. Amputated (loss of) foot, leg, arm, or hand	<input type="checkbox"/>	<input type="checkbox"/>
10. Parkinson's disease (Paralysis Agitans)	<input type="checkbox"/>	<input type="checkbox"/>
11. Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>
12. Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
13. Mental retardation (intelligence quotient within the lowest two percent of the general population)	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
14. Psychoneurotic disability following confinement for treatment in a recognized medical/mental hospital for a period in excess of 6 months.	<input type="checkbox"/>	<input type="checkbox"/>
15. Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
16. Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>
17. Cardiovascular (heart or blood vessel) disease	<input type="checkbox"/>	<input type="checkbox"/>
18. Total loss of hearing (loss of over half of hearing in each ear)	<input type="checkbox"/>	<input type="checkbox"/>
19. Compressed air sequelae (damage to lungs, ruptured ear drum, etc due to air concussion, blasting, explosion, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
20. Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
21. Hyperinsulinism (hypoglycemia)	<input type="checkbox"/>	<input type="checkbox"/>
22. Residual disability from poliomyelitis (Disability due to polio)	<input type="checkbox"/>	<input type="checkbox"/>
23. Ruptured intervertebral (back) disc	<input type="checkbox"/>	<input type="checkbox"/>
23. Chronic osteomyelitis (bone infection)	<input type="checkbox"/>	<input type="checkbox"/>
24. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS: _____

Signature of Employee

Date