I have reviewed the job description of the position for which I am applying for from my HR recruiter.

______________________________________      ______________________
Signature           Date

Do you have any condition, illness, injury, or are taking any medication that affects any of the following job related abilities for your position as identified in the job description?

☐ yes  ☐ no
If yes please explain _____________________________________________

______________________________________________________________

Please answer only the specific questions below that relate to the essential functions of the job for which you are applying as outlined in the attached job description.

1) VISION
Any vision problem which would affect with your ability to:
☐ yes  ☐ no  ☐ unknown               read or see objects clearly up close
☐ yes  ☐ no  ☐ unknown               see at a distance
☐ yes  ☐ no  ☐ unknown               distinguish colors
☐ yes  ☐ no  ☐ unknown               see in dim light
☐ yes  ☐ no  ☐ unknown               work at a computer monitor
☐ yes  ☐ no  ☐ unknown               work under fluorescent lighting

2) HEARING
Any hearing problem which would affect your ability to:
☐ yes  ☐ no  ☐ unknown               hear normal speaking voice
☐ yes  ☐ no  ☐ unknown               hear in noisy situations
☐ yes  ☐ no  ☐ unknown               requires you to avoid exposure to excessive noise

3) SPEECH
Any speech condition which affect your ability to:
☐ yes  ☐ no  ☐ unknown               communicate to others by speech
4) MOVEMENT & STRENGTH
Any problem with any of the following body parts that would affect your ability to:

a) SHOULDER or ELBOW
☐ yes ☐ no ☐ unknown move either shoulder or fully extend either arm overhead
☐ yes ☐ no ☐ unknown lift with either arm
☐ yes ☐ no ☐ unknown push or pull with either arm
☐ yes ☐ no ☐ unknown twist or turn either arm

b) HAND or WRIST
☐ yes ☐ no ☐ unknown do repetitive grasping or gripping
☐ yes ☐ no ☐ unknown do forceful grasping or gripping
☐ yes ☐ no ☐ unknown do repetitive or rapid finger movements

c) FOOT or LEG
☐ yes ☐ no ☐ unknown walk
☐ yes ☐ no ☐ unknown squat
☐ yes ☐ no ☐ unknown kneel
☐ yes ☐ no ☐ unknown climb stairs
☐ yes ☐ no ☐ unknown walk on uneven or slippery surfaces

d) NECK
☐ yes ☐ no ☐ unknown fully bend or rotate your neck
☐ yes ☐ no ☐ unknown hold your neck in a fixed position for a prolonged period of time

e) BACK
☐ yes ☐ no ☐ unknown sit for prolonged time
☐ yes ☐ no ☐ unknown stand for prolonged time
☐ yes ☐ no ☐ unknown walk for prolonged time
☐ yes ☐ no ☐ unknown bend your back frequently
☐ yes ☐ no ☐ unknown lift or carry up to 25 pounds
☐ yes ☐ no ☐ unknown lift or carry up to 45 pounds
☐ yes ☐ no ☐ unknown lift or carry greater than 45 pounds

5) BREATHING
Do you have any breathing problem which would affect your ability to:
☐ yes ☐ no ☐ unknown work outdoors in cold, hot or humid weather
☐ yes ☐ no ☐ unknown work around fumes, or dusts
☐ yes ☐ no ☐ unknown work around pollens, dusts, mold
☐ yes ☐ no ☐ unknown walk rapidly or for a prolonged time
☐ yes ☐ no ☐ unknown run
☐ yes ☐ no ☐ unknown climb stairs or walk uphill
☐ yes ☐ no ☐ unknown walk while carrying greater than 10 pounds
☐ yes ☐ no ☐ unknown walk while carrying greater than 25 pounds
☐ yes ☐ no ☐ unknown walk while carrying greater than 45 pounds
6) **CARDIAC**
Do you have any heart problem or are taking any medication which would limit your ability to:
- [ ] yes  [ ] no  [ ] unknown  walk rapidly or for a prolonged time
- [ ] yes  [ ] no  [ ] unknown  run
- [ ] yes  [ ] no  [ ] unknown  climb stairs or walk uphill
- [ ] yes  [ ] no  [ ] unknown  walk while carrying greater than 10 pounds
- [ ] yes  [ ] no  [ ] unknown  walk while carrying greater than 25 pounds
- [ ] yes  [ ] no  [ ] unknown  walk while carrying greater than 45 pounds
- [ ] yes  [ ] no  [ ] unknown  change positions rapidly

7) **BALANCE AND/OR CONSCIOUSNESS**
Do you have any condition or are taking any medication which could cause:
- [ ] yes  [ ] no  [ ] unknown  dizziness or loss of balance
- [ ] yes  [ ] no  [ ] unknown  fainting or loss of consciousness
- [ ] yes  [ ] no  [ ] unknown  seizures or convulsions
- [ ] yes  [ ] no  [ ] unknown  inability to do night shift or variable shift work

8) **PSYCHOLOGICAL AND/OR EMOTIONAL DISORDER**
Do you have any condition which would cause:
- [ ] yes  [ ] no  [ ] unknown  inability to work closely with others
- [ ] yes  [ ] no  [ ] unknown  inability to follow multiple directions or multitask
- [ ] yes  [ ] no  [ ] unknown  history of claustrophobia or inability to be in confined spaces or wear a face mask

9) **ALLERGIES**
- [ ] yes  [ ] no  [ ] unknown  to latex
- [ ] yes  [ ] no  [ ] unknown  to medication you may be exposed to at work
- [ ] yes  [ ] no  [ ] unknown  perfumes or smells – please list ________________
- [ ] yes  [ ] no  [ ] unknown  animals – please list ________________
- [ ] yes  [ ] no  [ ] unknown  foods – please list ________________

10) **IMMUNE SYSTEM**
- [ ] yes  [ ] no  [ ] unknown  Any condition that would limit your ability to work around infectious agents

11) **ANY OTHER CONDITION that would limit your ability to do any of the essential job functions as described in the job description?**
- [ ] yes  [ ] no  please explain ____________________________

I attest that the above is true to the best of my knowledge. I understand that knowingly answering any of the above questions falsely will lead to immediate dismissal.

_________________________________________ _____________________
Signature Date