Pre-Employment Physical Instructions

To schedule a Pre-Employment Exam, please call **928-774-3985.** Your appointment will be located at Vera Whole Health, 1500 E Cedar Ave, Suite 80, Flagstaff, AZ 86004.

For Pre-Employment Appointments that require an exam and are not related to Commercial Driver's Licenses (CDL), this packet includes the following forms that must be filled out prior to your appointment:

1. Employment Physical Examination Consent Form
2. Authorization to Release Patient Health Information
3. Pre-Employment Exam Form (You must work with your potential Employer to fill out the Functional and Environmental Requirements area on this form)

For Pre-Employment Commercial Drivers' License (CDL) related appointments, this packet includes the following forms that must be filled out prior to your appointment:

1. Employment Physical Examination Consent Form
2. Authorization to Release Patient Health Information
3. Medical Examiner's Report

Selected candidates must:

1. Plan to arrive at least 15 minutes prior to scheduled appointment time
2. Bring a list of all medications you're currently taking;
3. Bring your state-issued driver's license or other state-issued identification card

LATE ARRIVALS: In consideration of others, if you arrive 15 minutes or later after your scheduled appointment time, you may be rescheduled for another time and/or day if we're unable to work you in among the other scheduled appointments.

NOTIFICATIONS: You and your Department/Division will be notified of results within approximately three to five business days unless you're placed on a medical hold.

Employment
Physical Examination and/or Drug/Alcohol Testing
Consent and Release Form

I, _____, hereby give Vera Whole Health ("VERA") my consent to conduct, and express my willingness to undergo, a physical examination and/or drug/alcohol screening as requested by my employer or prospective employer identified below. I have signed a similar consent with my employer or prospective employer.

I also consent to the release of the results of the physical examination to my employer or prospective employer. Since I understand that my physical examination may also include a drug test (or I am obtaining a drug test only), I agree to provide and consent to the collection of a urine sample from me. I also understand and agree that this urine sample will be used to detect the presence of illegal narcotics, marijuana, and other drugs, or alcohol, as well as signs of abuse of legally prescribed drugs or alcohol.

I expressly and fully consent to the release to my employer or prospective employer of all my medical records related to the physical examination, and all drug/alcohol test results, that contain relevant information about my fitness and ability to perform the essential functions of the position I have applied for with my employer or prospective employer.

I agree to hold harmless, release and discharge VERA, and any of its designated medical personnel, agents, affiliates, or authorized testing laboratories, from any claims or potential liability, including attorney fees incurred, arising out of or related to any physical or medical examination and/or drug/alcohol testing, or the results of such examinations or testing that I have been asked to undergo by my employer or prospective employer. I also hereby agree not to file or pursue any complaints, claims, or legal actions of any kind against VERA or any of its employees, representatives, or agents arising out of their activities or actions performed in connection with these physical or medical examinations and/or drug/alcohol testing.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

(Signed) _____

Print Name: _____

Date _____

Employer or Prospective Employer:

_____

1500 E Cedar Ave, Suite 80, Flagstaff, AZ 86004 Phone: 928-774-3985 | Fax: 928-438-1771|

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient's Name:	Date of Birth:
Previous Name:	Phone Number:
I request and authorize Vera Whole Health to release healthcare information of the patient named above to:	Telephone Number: Fax Number : Address:

This request and authorization applies to the following health information:

- ☐ Complete medical record abstract (Includes 3 years of chart notes, most recent labs/pathology & diagnostic imaging reports)
- ☐ Laboratory/ Pathology Reports
- ☐ My health information relating only to the following treatment or condition: _____
- ☐ My health information only for the following date(s) _____
- ☐ Other (Please specify) __**Pre-Employment**_____

Patient Rights

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby specifically authorized to release all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded below.

_____ Mental health treatment

_____ Alcohol and/or drug abuse treatment

_____ HIV and AIDS Health Information

_____ Sexually Transmitted Diseases

This authorization will expire 1 year from the date signed below unless another date or event is entered here: _____.

Note: per state law, if disclosure is to an employer or financial institution for purposes other than payment, then the authorization will expire 1 year from date signed, unless specifically renewed by the patent.

MINORS AGE 13-17:

A minor patient's signature is required in order to release the following information: (1) conditions relating to the minors reproductive care including, but not limited to: contraception, pregnancy, sterilization, and sexually transmitted diseases, (2) alcohol and/or drug abuse (age 12 and older).

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

Patient signature _____ Date _____

Parent or Legal Guardian_____ Date_____

Relationship to patient, if other than patient _____

(You may be required to provide legal documentation as proof for power of attorney or guardianship)

Staff signature _____Date_____

Authorization to Release Patient Health Information

Instructions & Important information

Please read all information and instructions before completing and signing the authorization form.

PATIENT RIGHTS

You have the right to revoke or cancel this authorization, in writing, at any time.

CANCELLATION NOTICE

Records shall be released within fifteen days after receipt of a signed, dated release form. Since records are usually handled within 2 – 3 days after receipt, Vera Whole Health will not be held responsible for any release of medical information accomplished before receipt of a written notice of cancellation. Revocation takes place from the date of receipt of written request in the Compliance and Quality department.

Instructions for Canceling a Request:

1. You must provide a written request to the Compliance and Quality department asking for revocation/cancellation of the original record release.
2. We need to have your complete name, date-of-birth, telephone number (home/work) and the name of the person/agency that you authorized to receive the medical information.
3. After receipt of the notice by the Compliance and Quality department, telephone confirmation will acknowledge your withdrawal of authorization.
4. If the release has been accomplished, you will be notified by a representative of the Compliance staff. The release will be revoked for any further disclosure.
5. If you have any questions concerning the cancellation process, call the Compliance and Quality Department (206) 470-1871.

Pre-Employment
Physical Exam and Intake Form

Appointment Date:		
Patient's last name:	First:	Middle:
Birth date:	Age:	
Employer (potential or current):	Position (potential or current):	

Employee/Candidate Position Description

Purpose of examination: Pre-Employment_____ Other (Specify): _____
Description of what the position requires you to do:
Have you done this type of work before? Yes_____ No_____
If so, did you have any problems? Yes_____ No_____ Explain: _____
Will you be able to do this job? Yes_____ No_____ Uncertain _____

You must work with your potential employer to complete the Functional and Environmental Requirements areas below.

Check the box for each functional requirement and each environmental factor essential to the duties of this position. List any additional essential factors in the blank spaces. Also, if the position involves law enforcement, air traffic control, or firefighting, attach the specific medical standards for the examining provider to review.

Functional Requirements					
	Heavy lifting, 45 pounds and over		Repeated bending (_____ hours)		Both eyes required
	Moderate lifting, 15-44 pounds		Climbing, legs only (_____ hours)		Depth perception
	Light lifting, under 15 pounds		Climbing, use of legs and arms		Ability to distinguish basic colors
	Heavy carrying, 45 pounds and over		Both legs required		Ability to distinguish shades of colors
	Moderate carrying, 15-44 pounds		Operation of crane, truck, tractor, or motor vehicle		Hearing (aid permitted)
	Light carrying, under 15 pounds		Ability for rapid mental and muscular coordination simultaneously		Hearing without aid
	Straight pulling (_____ hours)		Ability to use and desirability of using firearms		Specific hearing requirements (Specify)

	Pulling hand over hand (_____ hours)		Near vision correctable at 13" to 16"		Use of fingers
	Pushing (_____ hours)		Far vision correctable in one eye to 20/20 and to 20/40 in the other		Both hands required
	Reaching above shoulder		Specific visual requirement (specify)		Walking (_____ hours)
	Standing (_____ hours)		Kneeling (_____ hours)		Crawling (_____ hours)
	Other :		Other :		Other :

Environmental Requirements					
	Outside		Electrical Energy		Work with pesticides
	Outside and Inside		Slippery or uneven walking surfaces		Protracted or irregular hours of work
	Excessive heat		Working around machinery with moving parts		Silica, asbestos, etc.
	Excessive humidity		Working around moving objects or vehicles		Fumes, smoke, or gases
	Excessive dampness or chilling		Working on ladders or scaffolding		Solvents (degreasing agents)
	Excessive cold		Working below ground		Grease and oils
	Dry atmospheric conditions		Use a respirator		Radiant energy
	Excessive noise, intermittent		Working with hands in water		Dust
	Constant noise		Explosives		Vibration
	Other :		Other :		Other :

Personal Health History								
Have you ever had or been told you had:								
		Asthma			Serious Allergies			Back Pain
		Bronchitis			Carpal Tunnel Syndrome			Chest Pain
		Diabetes			Emphysema			Epilepsy or other seizure disorders
		Fainting spells			Heating difficulty			Heart Attack
		Heart Disease			Hepatitis, cirrhosis or other Liver Disease			High Blood Pressure
		Jaundice			Muscular-skeletal Problems			Neurological Problems
		Nose Bleeds			Shortness of breath			T.B. Positive
		Herniated Disc			Hand or wrist injury			Hernia
		Vision Problems			Wear Contacts			Wear Glasses

Pre-Employment
Physical Exam and Intake Form

Personal Health History					
Y	N	Have you ever been hospitalized? If yes, when _____	Y	N	Do you smoke cigarettes now? Packs per day:_____Years_____
Y	N	Do you take prescription medication? List: _____ _____	Y	N	Have you smoked in the past? When did you quit?
Y	N	Do you take over-the-counter medication? List: _____ _____	Y	N	Do you use chewing tobacco or snuff? _____Times per day _____Years
Y	N	Are you allergic to any medication? List: _____	Y	N	Do you drink alcohol? _____Drinks per week
Y	N	Have you had a tetanus booster in the past five (5) years	Y	N	Do you use illegal drugs? List: _____
Y	N	Have you ever been off work for more than one day due to job-related illness or injury? If yes, when _____	Y	N	Do you exercise for 30 minutes three times a week or more?

Impairment History:					
Do you have					
Y	N	Loss of vision in either eye that cannot be corrected?	Y	N	Loss of hearing that requires a hearing aid?
Y	N	Decreased function in either hand, including grip and strength and the use of all fingers?	Y	N	Decreased function in neck or lower back?
Y	N	Decreased function in hips, knees, legs, ankles or feet?	Y	N	Other:

I, the undersigned, do hereby certify that to the best of my knowledge, the answers I have given to the questions above are true and I have no physical impairments except as stated above. I understand that any intentional omission or falsification of answers either verbally or in writing above may result in termination of my employment.

Patient Signature: _____ Date: _____