



## POST HIRING MEDICAL QUESTIONNAIRE

Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

This Home Health Agency, is committed to encouraging the employment of physically disabled persons but it also wants to protect its rights to seek reimbursement from the Special Disability Trust Fund in the event that an employee's pre-existing condition contributes to a subsequent injury by that employee in the course of employment. Your answers to this Questionnaire will not be used as the bases for deciding whether to employ you and your response to this questionnaire will be considered and treated as a confidential medical record which will not be included in your personnel file. Warning! This Home Health Agency, and its insurance carrier intend to rely upon the information provided by you in this Questionnaire. It is your obligation to provide truthful and complete information in response to the questions presented below. If it is later determined that you gave an intentional false response, you may be disqualified from receiving workers' compensation benefits. In addition, you may be subject to termination of employment in the event that it is later determined that you deliberately falsified your responses to this Questionnaire.

**INSTRUCTIONS:** Answer YES or NO to the following questions. If your answer is YES, list the approximate date of injury or treatment.

Question	Yes/No Date	Question	Yes/No Date
1. Have you ever had a back injury?		26. Do you have or have you ever had hyperinsulinism?	
2. Have you ever had a hematite intervertebral disc in your back?		27. Do you have or have you ever had chronic osteomyelitis?	
3. Have you ever had a back surgery for a removal of a disc?		28. Do you have or have you ever had thrombophlebitis?	
4. Have you ever had a neck injury?		29. Do you have or have you ever had a total dizziness?	
5. Have you ever had a hematite disc in you neck?		30. Do you have or have you ever had a magmatic fever?	
6. Have you ever had a neck surgery for removal of a disc?		31. Do you have or have you ever had a varicose veins or leg ulcer?	
7. Have you ever had a knee injury?		32. Do you have or have you ever had tuberculosis?	
8. Have you ever had a surgery on either of your knees?		33. Do you have or have you ever had allergies or asthma?	
9. Have you ever had a shoulder injury?		34. Do you have or have you ever had skin trouble?	
10. Have you ever had a surgery on either of you shoulders?		35. Do you have or have you ever had reactions to serum or drugs?	
11. Have you ever had an elbow injury?		36. Do you have or have you ever had kidney trouble?	
12. Do you have or have you ever had an amputation of your foot, leg, arm or hand?		37. Do you have or have you ever had muscular dystrophy?	
13. Do you have or have you ever had epilepsy?		38. Do you have or have you ever had ulcers?	
14. Do you have or have you ver had diabetes?		39. Do you have or have you ever had a head injury?	
15. Do you have or have you ever had cardiac disease (heart trouble)?		40. Do you have or have you ever had a mental retardation?	
16. Do you have or have you ever had Marie-Strumpell disease?		41. Do you have or have you ever had cancer?	
17. Do you have or have you ever had total loss of sight of one or both eyes or a partial loss of corrected vision of more than 75% bilaterally?		42. Do you have or have you ever had any permanent physical condition which constitutes a 20% impairment of a member of the body as a whole?	
18. Do you have or have you ever had a cerebral disability from poliomyelitis?		43. Are you new or have you ever been obese (30% over normal body weight)?	
19. Do you have or have you ever had a cerebral palsy?		44. Do you have or have you ever had arthritis or rheumatism?	
20. Do you have or have you ever had multiple sclerosis?		45. Have you ever been treated/advised to seek treatment for alcoholism?	
21. Do you have or have you ever had Parkinson's disease?		46. Have you ever had a hernia? If the answer is yes, where is the location of the body?	
22. Do you have or have you ever had vascular disorder?		47. Have you ever been treated for substance abuse or addiction?	
23. Have you ever had psychoneurotic disability following treatment in a recognized Medical or mental institution, in excess of 6 months?		48. Have you ever had any injury, surgery, or disability which has not been described in the questions above? (If so, state in detail the nature of the injury, surgery or disability):.	
24. Do you have or have you ever had hemophilia?			
25. Do you have or have you ever had ankylosis of a major weight-bearing joint?		49. Do you have or have you ever had a high blood pressure?	

**All statements and information given in this application are true, to the best of my knowledge and belief.**



# Level 1 Criminal History Request

Any individual required by law to undergo background screening in accordance with Chapter 435, Florida Statutes, that is employed, seeking employment or otherwise associated with a provider currently licensed or seeking licensure through the Agency for Health Care Administration (Agency), may complete this form for the purpose of requesting such screening through the Agency.

**Health Care Provider (Required Information):**

**Name:** \_\_\_\_\_ **AHCA License #:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

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**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

**Type of Provider:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Home Health Agency                 | <input type="checkbox"/> Nursing Home Facility              | <input type="checkbox"/> Laboratory     |
| <input type="checkbox"/> Homemaker, Companion Sitter Agency | <input type="checkbox"/> Adult Day Care Center              | <input type="checkbox"/> Hospital       |
| <input type="checkbox"/> Assisted Living Facility           | <input type="checkbox"/> Adult Family Care Home             | <input type="checkbox"/> Nurse Registry |
| <input type="checkbox"/> Health Care Services Pool          | <input type="checkbox"/> Home Medical Equipment             | <input type="checkbox"/> Hospice        |
| <input type="checkbox"/> Health Care Clinic                 | <input type="checkbox"/> Other (please specify type): _____ |   |

**Type of Applicant:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Administrator                            | <input type="checkbox"/> Exemption Application | <input type="checkbox"/> RN/LPN/CNA    |
| <input type="checkbox"/> Financial Officer                        | <input type="checkbox"/> Employee/Staff Person | <input type="checkbox"/> Relief Person |
| <input type="checkbox"/> Owner or Operator w/ 5% interest or more |  |  |

**Identifying Information:** Please print legibly or type information.

The Florida Department of Law Enforcement requires specific identifying information upon submission of a criminal history request, including the social security number if available (section 11C-6.003(1), Florida Administrative Code). Disclosure of your social security number is mandatory. The Agency for Health Care Administration shall use such information for purposes of internal identification.

**Name:** \_\_\_\_\_  
 Last First Middle Maiden

**Current Mailing Address:** \_\_\_\_\_  
 \_\_\_\_\_  
 City State Zip

**Social Security No.:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
 or Individual Taxpayer Identification Number (ITIN)

**Race:**  W  B  I  A  U **Sex:**  Male  Female

W=WHITE B=BLACK I=AMER. INDIAN OR ALASKAN A=ASIAN OR PACIFIC ISLANDER U=UNKNOWN (INDICATE HISPANIC AS BLACK OR WHITE BASED ON SKIN COLOR)



**PHYSICAL EXAMINATION FORM**

In my opinion, \_\_\_\_\_ is physically and mentally able to perform the duties of \_\_\_\_\_ and is free of communicable disease.

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE

**Mantoux Test OR CHEST X-RAY**

EMPLOYEE NAME: \_\_\_\_\_

TEST DATE: \_\_\_\_\_ NEGATIVE: \_\_\_\_\_ POSITIVE: \_\_\_\_\_

READING DATE: \_\_\_\_\_

READ BY: \_\_\_\_\_

RECOMMENDATIONS\* \_\_\_\_\_  
\_\_\_\_\_

EMPLOYEE'S SIGNATURE: \_\_\_\_\_  
\_\_\_\_\_

I Certify that I am free of any lower back ailments of any other ailment which could be prevent me from performing my duties in a satisfactory manner.

I further certify that he/she does not appear to be at risk of transmitting communicable disease.

EMPLOYEE'S SIGNATURE: \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_



# MEDICAL EXAMINATION CERTIFICATE

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

The following information is required by the Department of Health, Title XXII, Chapter I, Section 70723, for all persons working in the health field:

### PHYSICAL EXAMINATION (to be completed by physician)

Height	Weight	Blood Pressure	Pulse
_____	_____	_____	_____

Physical Exam:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MANTOUX** Test Result \_\_\_\_\_

Chest X-ray (if indicated) \_\_\_\_\_ EKG (if indicated) \_\_\_\_\_ Date \_\_\_\_\_

Urinalysis \_\_\_\_\_

VDRL (RPR) \_\_\_\_\_ Other Lab/Results \_\_\_\_\_

Any Communicable Disease:  
\_\_\_\_\_  
\_\_\_\_\_

I have examined the above-named individual and I certify that he/she is mentally and physically able to perform the duties of his/her job. I further certify that he/she is free from communicable disease.  
I further certify that he/she does not appear to be at risk of transmitting communicable disease.

Physician's Name \_\_\_\_\_ Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physicians Address \_\_\_\_\_ Telephone \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_