Health Questionnaire (Post Job Offer)

This questionnaire is not being used as the basis for deciding whether to employ you. It is solely for the purpose of providing information to the Florida Special Disability Trust Fund in appropriate cases.

Personal Information

Date:

Name: Last First Middle

Address: Street Appt.# City State ZIP

Soc. Sec.#: Sex: ☐ Male ☐ Female Date of Birth: Height: Weight:

Medical History

Do you have or have you ever had any of the following? You must answer all questions. Any yes answer must be fully explained below.

	Yes	No		Yes	No
Epilepsy	☐	☐	Arthritis	☐	☐
Diabetes	☐	☐	Allergies	☐	☐
Cardiac (Heart) Disease	☐	☐	Hemophilia	☐	☐
Marie Strumpell Disease	☐	☐	HIV Virus	☐	☐
Any Loss of Vision	☐	☐	Osteomylitis	☐	☐
Polio	☐	☐	Stiff Joints	☐	☐
Any Amputation	☐	☐	Hypoglycemia	☐	☐
Cerebral Palsy	☐	☐	Muscular Dystrophy	☐	☐
Multiple Sclerosis	☐	☐	Thrombophlebitis	☐	☐
Parkinson's Disease	☐	☐	Herniated Intervertebral Disc	☐	☐
Vascular Circulation Disorder	☐	☐	Back Surgery	☐	☐
Cancer	☐	☐	Psychiatric or Psychological Treatment or Evaluation	☐	☐
Skin Trouble	☐	☐			

Have you ever received treatment for a back, neck or knee condition or a head injury?

Do you now or have you ever suffered from aches or pains of the back?

Have you ever had any surgery?

Do you now or have you ever had any physical disabilities, impairments or handicaps?

Have you ever had a workers' compensation injury?

Are there any questions you do not understand? If yes, which question(s)?

I understand and agree that if I am injured on the job, regardless of how minor, I am to report the injury immediately to my supervisor.

I further understand and agree that my employer's workers' compensation carrier will determine the medical facility and/or doctors I am to use.

I certify the above answers to be true and correct. I understand that any false or misleading answers to these questions will be sufficient reason for denial of benefits under the Florida Workers' Compensation Act, and will be the basis for termination.

Date: Employee Signature:

Client#: Company Name: Witnessed By:

This form may be downloaded from www.abcopayroll.com