



NAME \_\_\_\_\_

SSN (last 4 digits) \_\_\_\_\_

DOB \_\_\_\_\_

GENDER IDENTITY  Man  Woman  \_\_\_\_\_

SEX ASSIGNED AT BIRTH  Male  Female

Do you need any help with reading or writing in order to complete this form?  NO  YES

Company you will be working for \_\_\_\_\_

Position you have applied for \_\_\_\_\_

Have you read, and do you understand, the physical requirements of your job, as detailed by the job description you received?  NO  YES

<b>Do you have any disorder or physical impairment which could interfere, in any way, with full performance of the duties of the position for which you are applying?</b>	<input type="checkbox"/> NO	<input type="checkbox"/> YES
If yes, please describe:		
<b>If you answered yes, do you need an accommodation that would allow you to perform the duties of the position for which you are applying?</b>	<input type="checkbox"/> NO	<input type="checkbox"/> YES
If yes, please describe:		
<b>Are you color blind?</b>	<input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> DON'T KNOW

*The safe harbor notice states that "GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members." In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family members' genetic tests, the fact that an individual or an individual's family members sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family members, or an embryo lawfully held by an individual, or family members receiving assistive reproductive services.*

**Do you have or use any of the following, WHICH COULD IMPACT YOUR ABILITY TO SAFELY PERFORM YOUR JOB FUNCTIONS? If yes, please explain.**

1. Allergies/Latex?	NO	YES
2. Medications?	NO	YES
3. Have you had any surgeries within the previous year which could impact your ability to safely perform your job functions?	NO	YES
4. Are there any other health problems, not listed, that may impact your ability to safely perform your job duties? If yes, please explain.	NO	YES

Applicant Signature: \_\_\_\_\_

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

**APPLICANT STOP HERE**