



WESTWAYS STAFFING SERVICES, INC.

Employee Health Survey

Emergency Notification

Should I be involved in an accident or emergency situation, please notify:

Last Name: _____ First Name: _____

Address: _____
Street City State Zip

Telephone: _____
Home Business

Physician Designation

I authorize the following physician who has my medical records and history to be contacted should I incur an illness or work related injury while on assignment and in the employ of Westways Staffing Services, Inc. Should my physician change, I assume responsibility for notifying Westways Staffing Services, Inc.

Health Clearance

Date of last physical exam: _____

The name and address of the physician and/or facility that performed the physical exam:

Name: _____

Address: _____
City State Zip

Telephone: _____

TB Status

Date of last PPD: _____ Date read: _____ Results: _____

Date of last Chest X-ray: _____ Results: _____

Allergies

- | | | |
|---|--------------------------------|---|
| <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Latex | <input type="checkbox"/> Morphine, Codeine, Demerol or other narcotics/controlled |
| <input type="checkbox"/> Any food: | | <input type="checkbox"/> Novocaine, Xylocaine, or other anesthetics |
| <input type="checkbox"/> Alcohol preparations | | <input type="checkbox"/> Penicillin or other antibiotics |
| <input type="checkbox"/> Aspirin, or other pain medications | | <input type="checkbox"/> Sulfa Drugs or medications |
| <input type="checkbox"/> Hay fever or seasonal allergies | | <input type="checkbox"/> Tetanus Antitoxin or other Sera |
| <input type="checkbox"/> Iodine or other cleaning solutions | | <input type="checkbox"/> Any other drug group or medication: Name |

Do you have any physical condition which precludes or would limit your ability to perform certain tasks or responsibilities of the job for which you are applying?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you presently pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there pending, or have you applied for a pension, or compensation for any existing disability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



WESTWAYS STAFFING SERVICES, INC.

Are you now being treated or have you ever sought treatment for:

	Yes	No		Yes	No		Yes	No
Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Small Pox	<input type="checkbox"/>	<input type="checkbox"/>
Back Strain	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sprains	<input type="checkbox"/>	<input type="checkbox"/>
Back Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Immune System Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stone	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers: Peptic	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Dislocations	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Condition	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever been:

	Yes	No
Refused Employment?	<input type="checkbox"/>	<input type="checkbox"/>
Unable to hold a position for health reasons?	<input type="checkbox"/>	<input type="checkbox"/>
Unable to hold a position for medical reasons?	<input type="checkbox"/>	<input type="checkbox"/>
Unable to work due to medical reasons?	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalized in the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
Advised to have diagnostic tests that were not completed?	<input type="checkbox"/>	<input type="checkbox"/>
Advised to have a hospitalization that was not completed?	<input type="checkbox"/>	<input type="checkbox"/>
Advised to have a surgery which was not completed?	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever:

	Yes	No
Worked with cytotoxic drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Worked with radioactive materials?	<input type="checkbox"/>	<input type="checkbox"/>
Had any serious illness in the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
Had your work restricted for health reasons?	<input type="checkbox"/>	<input type="checkbox"/>
Had a surgical procedure?	<input type="checkbox"/>	<input type="checkbox"/>
Procedure: _____		Date: _____
Procedure: _____		Date: _____
Had treatment or consultation for musculoskeletal injury?	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever received/ had:

German Measles	<input type="checkbox"/> Vaccine	<input type="checkbox"/> Titer	Tetanus?	<input type="checkbox"/> Vaccine	<input type="checkbox"/> 10 yr Booster
Measles	<input type="checkbox"/> Vaccine	<input type="checkbox"/> Titer	Steroids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mumps	<input type="checkbox"/> Vaccine	<input type="checkbox"/> Titer	Gamma Globulin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rubella	<input type="checkbox"/> Vaccine	<input type="checkbox"/> Titer	Hepatitis B Vaccine Series (3) completed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diphtheria	<input type="checkbox"/> Vaccine	<input type="checkbox"/> Titer	If yes, list date: Month/Year: _____		
Pertussis	<input type="checkbox"/> Vaccine	<input type="checkbox"/> Titer	If no, check those completed:		
Small Pox	<input type="checkbox"/> Vaccine	<input type="checkbox"/> Titer	<input type="checkbox"/> 1 Date: (Month/Year) _____		
BCG	<input type="checkbox"/> Vaccine	<input type="checkbox"/> Titer	<input type="checkbox"/> 2 Date: (Month/Year) _____		
X-ray	<input type="checkbox"/> Chest	<input type="checkbox"/> Spine			

Are you taking any medication or substance (prescription or otherwise) that may cause a positive result on a drug test?

I certify that the information provided in this health survey is true, correct and complete. I understand that any misinterpretation, omission or falsification on this documentation may result in my failure to receive an offer of employment or, if I am hired, my immediate dismissal from employment.

Print Name _____

Signature _____

Date _____