



**OCCUPATIONAL MEDICINE & WALK-IN CLINIC**

106 Heritage Parkway; Broussard, LA 70518

Phone: 337-856-7500 Fax: 337-856-7502

---

Informed consent for post offer of employment  
Functional testing and release of medical information

I desire to engage voluntarily in the post-offer of employment functional testing program in order to ascertain whether or not I have the abilities to perform the essential functions of the job I am applying for. I understand that the activities are designed to place a gradually increasing workload on the cardio respiratory and musculoskeletal system. There is a risk of certain changes that might occur during or following the exercise. The changes might include abnormalities of blood pressure, heart rate, and musculoskeletal pain or injury.

I understand that I am responsible for monitoring my own condition throughout the testing process and should any unusual symptoms occur, I will cease my participation and inform the evaluator of the symptoms.

In the event that a medical clearance must be obtained prior to my participation in the testing program, I agree to the consent of my physician by MedXcel or its designed agents in order to obtain written permission from my physician prior to the commencement of the testing program. I also agree to the release of medical records related to the determination of my ability to safely participate in the testing program.

Also, in consideration for being allowed to participate in the \_\_\_\_\_ (company name) Post-Offer of Employment Testing Program, I agree to assume the risk of such activities required to determine my suitability for the essential job function. I further agree to not hold MedXcel and its staff members conducting the testing program from any and all claims, suits, losses, or related causes of action for damages, including, but not limited to such claims that may result from injury, or death, accidental or otherwise, during or arising in any way from the test activities.

---

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Telephone Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

Name of personal Physician: \_\_\_\_\_ Phone number: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

---



OCCUPATIONAL MEDICINE & WALK-IN CLINIC

106 Heritage Parkway; Broussard, LA 70518

Phone: 337-856-7500 Fax: 337-856-7502

Lift Test
Pre-Work Screen

Company: \_\_\_\_\_

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

Name: \_\_\_\_\_

Table with 5 columns: Test Description, Critical Demands, Score, Met, Not Met. Rows include STANDING, WALKING, LIFTING (Maximum lift, Floor to waist, Overhead lift, Unilateral carry), Bending (occasionally), LADDER, FINE MOTOR SKILLS, PUSH, and ROPE SWING.

COMMENTS: \_\_\_\_\_

Physical abilities (DO/DO NOT) match the functional requirements of a \_\_\_\_\_ (job description).
Modifications of the job or changes in the applicant's physical abilities (WOULD/ WOULD NOT) be necessary in order for him or her to do their tasks.

Evaluator: \_\_\_\_\_

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