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: ____

Test Description	Critical Demands	Score	Met	Not Met
STANDING				
(Hard uneven surface)	Constantly	______	______	______
WALKING				
(Casual, movement of hard, uneven surface)	Constantly	______	______	______
LIFTING				
Maximum lift	100 lbs (x1)	______ lbs	______	______
Floor to waist	75 lbs (x3)	______ lbs	______	______
Overhead lift	50 lbs (x3)	______ lbs	______	______
Floor to waist	50 lbs (x3)	______ lbs	______	______
Unilateral carry	50 lbs (x5)	______ lbs	______	______
Bending (occasionally)				
Forward bending	7 reps	______ reps	______	______
Backward bending	7 reps	______ reps	______	______
Side bending	7 reps	______ reps	______	______
Rotation	7 reps	______ reps	______	______
LADDER				
3 Steps	5 reps	______ reps	______	______
FINE MOTOR SKILLS				
Overhead	Frequently	______ min	______	______
PUSH				
Pushups	5 reps	______ reps	______	______
ROPE SWING				
Rope hang	10 seconds	______ sec	______	______

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: __________________________