EMPLOYER INSTRUCTIONS
FOR MEDICAL QUESTIONNAIRE

PURPOSE OF MEDICAL QUESTIONNAIRE

The Medical Questionnaire has been developed to comply with the requirements of the Americans with Disabilities Act (ADA), the New Mexico Human Rights Act (NMHRA), and the Workers' Compensation Act (WCA). The Medical Questionnaire is designed to collect information for three reasons:

(1) for the employer to determine the candidate's ability to perform the essential job duties of the position, either with or without reasonable accommodation, for which the candidate was given a conditional offer;

(2) for the employer to determine whether and what reasonable accommodation(s) may be necessary to allow the candidate to perform the essential job duties of the position and whether any necessary accommodation(s) would create an undue hardship; and

(3) for the employer/carrier to evaluate any workers' compensation claims submitted by the candidate in the future.

Employers are strongly encouraged to use the Medical Questionnaire, especially for any job categories that require physical labor or for which there is an increased risk of workplace injury. Appropriate and responsible use of the Medical Questionnaire may provide significant protection to the employer when an employee suffers a future workplace injury.

WHEN TO USE MEDICAL QUESTIONNAIRE

- The Medical Questionnaire may only be used <u>after</u> a conditional job offer is made to the candidate but <u>before</u> the candidate begins employment. A job offer may be conditioned on the candidate's satisfactory completion and review of the Medical Questionnaire and any required medical examination or follow-up inquiry.

- The Medical Questionnaire may <u>not</u> ever be used before the candidate is given a conditional job offer.

HOW TO USE MEDICAL QUESTIONNAIRE

- The Medical Questionnaire must be given to all candidates in the same job category (e.g., welders) who are given a job offer.

- The employer should review the information provided in the Medical Questionnaire to evaluate whether the candidate is able to perform the essential job duties of the position. If any information provided in the Medical Questionnaire causes concern or casts any doubt on whether the candidate is able to perform the essential job duties of the position, the employer may require a medical examination and/or ask follow-up questions medically related to information learned in the Medical Questionnaire.

- If the conditional job offer is withdrawn based on the results of post-offer medical examination or inquiry, the reason(s) for the withdrawal must be job-related and necessary for the business. The employer must be able to show that no reasonable accommodation would have enabled the candidate to perform the essential job duties or that any necessary accommodation would impose an undue hardship.

- The employer may not withdraw a conditional job offer based solely on the answers to the Medical Questionnaire or because the candidate has previously made a workers' compensation claim.

- More information and guidance about preemployment disability-related questions and medical examinations can be found at https://www.eeoc.gov/selected-enforcement-guidances-and-other-policy-documents-ada.

- **Employers are strongly encouraged to consult with legal counsel before administering a follow-up medical examination based on information provided in the Medical Questionnaire and/or before making any employment decisions based on the results of a post-offer medical examination or inquiry.**

HOW TO STORE MEDICAL QUESTIONNAIRE

- The Medical Questionnaire must be kept strictly confidential in a separate medical file apart from the personnel file.

- The Medical Questionnaire for any candidate whose conditional job offer has been withdrawn must be kept by the employer for at least one year following the withdrawal of the offer.

MEDICAL QUESTIONNAIRE

(EMPLOYER'S NAME)

This questionnaire may be used to identify a worker's physical ability to perform the job he/she has been conditionally hired for and/or analyze or evaluate workers' compensation claims submitted in the future.

MEDICAL QUESTIONNIARE (Please print)

Name _____

Address _____

Date of Birth _____

Social Security Number

Have you ever suffered a work related injury? ☐ Yes ☐ No

Have you ever filed for and/or received Workers' Compensation benefits? ☐ Yes ☐ No

If yes, list dates and describe when such claims were filed, and/or benefits received.

Have you ever suffered an illness or injury other than at work where you were off work, and/or had to limit your activities for more than one week?

☐ Yes ☐ No

If yes, list dates and describe all such injuries, and/or illnesses suffered.

Have you ever been in an automobile accident? ☐ Yes ☐ No

If yes, list dates of all such accidents, all injuries suffered including any physical restrictions imposed.

List your family physician:

Please check any of the following activities for which you have, or have had, a restriction:

Lifting ☐	Standing ☐	Squatting ☐
Carrying ☐	Walking ☐	Crawling ☐
Sitting ☐	Bending ☐	Climbing ☐

Give a brief description of any restrictions checked above.

NOTICE: Under Section 52-1-28.3, NMSA 1978, of the New Mexico Workers' Compensation Act provides that the worker shall be entitled to NO future workers' compensation benefits if he or she knowingly and willfully conceals or makes a false representation about the information requested.

I hereby certify that the information listed above is true, correct, and complete, to the best of my knowledge and that I understand all of the questions listed in this questionnaire. I further certify that I have read and understand the above Notice provision indicating that I will be entitled to NO future workers' compensation benefits if I knowingly and willfully conceal or make a false representation about the information requested.
(Please make sure the questionnaire is filled out completely before signing)

Employee Signature _____ Employer Signature _____

Date _____ Date _____

SAMPLE V.20161107

CUESTIONARIO MÉDICO

(NOMBRE DEL EMPLEADOR)

Este cuestionario puede ser usado para identificar la capacidad y el estado físico del trabajador para desempeñar el trabajo que a el/ella se le haya asignado o para evaluar o analizar reclamos de cuando se lastiman en el trabajo, sometidos en el futuro.

CUESTIONARIO MÉDICO (Escriba)

Nombre _____

Dirección _____

Fecha de Nacimiento _____

Número de Seguro Social

¿Ha tenido algún daño/lastimadura anteriormente en el trabajo? ☐ Sí ☐ No

¿Ha recibido o reclamado beneficios de Compensación para los trabajadores? ☐ Sí ☐ No

Cuando; anote fechas y detalles:

¿Ha sufrido algún daño/lastimadura/enfermedad que no haya sido en el trabajo y que haya tenido que limitar sus actividades por más de una semana?

☐ Sí ☐ No

Cuando; anote fechas y detalles:

¿Ha tenido algún accidente automovilístico? ☐ Sí ☐ No

Cuando; anote fechas y detalles:

¿Quién es su médico/doctor de familia?

Marque las siguientes actividades por las que haya tenido o tenga restricciones:

Levantar ☐	Estar de pie ☐	Ponerse en cuclillas ☐
Cargar ☐	Camina ☐	A gatas ☐
Sentar ☐	Doblar/encorvar ☐	Escalar ☐

Si algo está marcado arribe, dé una descripción/ explicación en detalle:

Sección 52-1-28.3, NMSA 1978, del Acto De Compensación de Trabajadores provee consecuencias para declaraciones o representaciones falsas escritas en este cuestionario, que pueden causar que el trabajador pierda sus beneficios de compensación de los trabajadores.

La información enumerada arriba es verdadera y correcta por mi mejor conocimiento y entendí todas la preguntas listadas arriba. Yo certifico que he leído y entendido la provisión notificada que indica que yo no voy a recibir beneficios de compensación de los trabajadores, si yo hábilmente y con conocimientos oculté y di falsa información o representación de mi condición médica. (Por favor este seguro(a) que el formulario esté completamente lleno antes de firmarlo)

Firma del empleado _____ Firma del empleador _____

Fecha _____ Fecha _____