Pre-Placement Assessment

Information requested on this form is to help determine your ability to perform the job functions for the position you have been offered at Marshfield Clinic Health System or one of its affiliated organizations including Marshfield Clinic, Inc., Family Health Center of Marshfield, Inc., Security Health Plan of Wisconsin, Inc., Lakeview Medical Center, Inc. of Rice Lake, MCHS Hospitals, Inc., and all facilities owned and/or operated by the aforementioned organizations. Information provided will remain confidential to the Human Resources and Employee Health & Safety Departments only. Information will not be released from these departments unless expressly requested by you, or in the event of an emergency.

Demographics

Name:	Position Offered:	Department:
Social Security Number:	Gender: ☐Female ☐ Male	Date of Birth:	Age:

Address:	City:	State:	Zip:	Phone:

Please read and initial each statement, and sign below as acknowledgement of information provided:

____ I understand that my employment is contingent upon this pre-placement assessment, as well as other requirements that have been explained to me. I understand that Employee Health & Safety will allow up to two (2) weeks for me to provide requested records for any physical or medical condition that may affect my ability to perform the essential functions of this job with or without reasonable accommodation.

____ I have reviewed the job description, including the essential functions and physical requirements of the position I have been offered. I am able to perform the essential functions of this position with or without reasonable accommodations.

____ I understand that Marshfield Clinic Health System, or one of its affiliated organizations as defined above, may do a background check to determine if I have ever had a prior workers compensation claim. I understand that any falsification of the workers compensation portion of this pre-placement assessment may be grounds for withdrawal of the offer of employment, or my immediate release from employment.

____ I understand that I will be screened for Hepatitis C and Hepatitis B. If I test positive for Hepatitis B antigen or Hepatitis C antibody, I may be restricted from performing exposure-prone procedures.

____ I agree to comply with the mandatory vaccination policy (or others) of Marshfield Clinic Health System, or any of its affiliated organizations as defined above.

____ I agree to disclose to Employee Health & Safety the use of all medications that I am taking, including any controlled prescription medications (i.e., narcotics, pain medication), and any other current or past medical treatment.

____ I agree to comply with treatment (i.e., medications, therapy) prescribed by my healthcare provider in which non-compliance may affect my ability to safely perform my job duties or would be a safety risk to myself, co-workers, patients, or others.

____ I understand that if my urine drug screen results are positive, as determined by a certified Medical Review Officer, I will be denied employment with Marshfield Clinic Health System or any of its affiliated organizations as defined above, at this time and for a period of one year from the date of the results.

I have read the above statements and agree to comply with all requirements in this pre-placement assessment. I certify that the information I provide on this pre-placement assessment is accurate to the best of my knowledge. I understand that any misstatement, misrepresentation, omission, or falsification of any portion of this pre-placement will be sufficient grounds for withdrawal of the contingent offer of employment, or my immediate release from employment.

I understand that this examination is to determine my work capability and it is not intended to be a health evaluation for any other purpose. I understand that my health is my personal responsibility and I will consult with my personal physician regarding health problems. I further understand and authorize medical reasons be given to the manager who has authorize the offer of employment, if I have failed the exam or if restrictions are placed on my work capacity.

Applicant signature: _____ Date: _____