CONFIDENTIAL

Applicant Name: _____ Social Security Number: _____

Montgomery County Government (MD)
OCCUPATIONAL MEDICAL SERVICES
27 Courthouse Square, Suite 184, Rockville, Maryland 20850
Phone: (240) 777-5118 MedicalInfo.OMS@montgomerycountymd.gov Fax: (240) 777-5132

MEDICAL HISTORY REVIEW FORM

Purpose: You have received an offer of employment, conditioned upon your successful completion of a medical examination and/or a medical history review form. This form will be used by an independent 3rd party vendor who operates as the County's Independent Medical Examiner to:

- determine your ability to perform the essential functions of the position;
- confirm that you meet any and all applicable federal or state medical requirements for the position; and
- if applicable, review any request you may make for a reasonable accommodation under the Americans with Disabilities Act of 1990, as amended.[1]

Confidentiality: Any information you provide herein will be considered protected health information and will be maintained in accordance with the requirements of the Health Insurance Portability and Accommodation Act (HIPAA), the Maryland Confidentiality of Medical Records Act, and all other applicable state and local laws. Access to the information is limited to the 3rd party Employee Medical Examiner within Occupational Medical Services, or other authorized persons in accordance with County laws and regulations.

FREQUENTLY ASKED QUESTIONS

1. What should I expect to happen once my form is submitted?
    a. Your information will be reviewed by the 3rd party clinical staff for clearance. If additional information is needed, you will be contacted directly.
2. Who has access to my completed Medical History Review Form?
    a. 3rd party clinical staff and authorized persons in accordance with county law and regulations
3. Will my new supervisor receive details of this form from Occupational Medical Services?
    a. No
4. Who may I contact with questions about this form?
    a. 3rd party clinical staff at 240 777-5118
5. How do I submit my form?
    a. Feel free to submit via the secure link sent to you by your recruiter, via email or fax listed on this form

CANDIDATE INFORMATION

_____

Last Name First Name Middle Initial Position

_____

Home Address (Street, City, State, Zip Code) Social Security Number

_____

Phone Number Email Address Date of Birth Sex

_____

Emergency Contact (Name, Address, Phone)

[1] This information may be used to evaluate any future eligibility for disability or disability retirement benefits. This information will not be used to determine eligibility for insurance benefits.

CONFIDENTIAL

Applicant Name: _____ Social Security Number: _____

POSITION-RELATED MEDICAL QUESTIONS

1. The position I've been offered is:
   - ☐ Clerical/Administrative
   - ☐ Supervisory/Management
   - ☐ Animal Control
   - ☐ Public Health/Child Welfare
   - ☐ Recreation/Leisure
   - ☐ Other:

2. Do you fully understand all essential functions and demands of your position as outlined in the class spec and the job posting?
   - ☐ No.
   - ☐ Yes.

   Optional comment box:

3. Do you currently have any medical, psychological or physical condition or disability or other issue that would interfere with your ability to do the job you've been offered or may require an accommodation?
   - ☐ No.
   - ☐ Yes. If checking yes, briefly describe below.

4. Do you have, or have you had within the last 3 years, any condition that limits your ability to perform prolonged standing, or been told to limit your lifting, pushing or pulling of objects?
   - ☐ No.
   - ☐ Yes. If checking yes, please explain fully.

CONFIDENTIAL

Applicant Name: _____ Social Security Number: _____

CERTIFICATION OF INFORMATION

I certify that I have reviewed the forgoing information supplied by me and that it is true and complete to the best of my knowledge. Further, I understand that:

1. A final offer of employment is conditioned upon an independent 3rd party who serves as Employee Medical Examiner's determination of my ability to perform the essential functions of the position with or without a reasonable accommodation and to satisfy any applicable federal or state medical requirements for the position;
2. Any intentionally false or misleading information may result in the rejection of my application for employment or in my discharge from County employment. Any false or misleading statement may also exclude me from future coverage in the County medical disability retirement or disability benefit programs.
3. I may be required to provide additional medical information and/or undergo further medical evaluation as a condition of employment if requested by the 3rd party Employee Medical Examiner.
4. Upon written request, a copy of this form or any component of my medical record will be made available to me in accordance with MCPR Section 4.

Applicant's Signature: _____ Date: _____
(or signature of Parent if applicant is a minor)

For Internal Use Only (Recruiter to Complete)

Department: _____ Division: _____

Position: _____

OMS Exam Date: _____ Requested Clearance Date: _____

Check here for Temporary/Seasonal Position ☐

Recruitment Specialist: _____ Hiring Department Contact: _____

Recruitment Backups: _____ and _____

CONFIDENTIAL

Applicant Name: _____ Social Security Number: _____

CLINICAL STAFF COMMENTS

Physician/Nurse comments, summary or elaboration of all pertinent data.

[ ] No relevant medical history or physical limitation identified. No accommodation requested.

[ ] Candidate is cleared for the position.

[ ] OMS visit required – clinical staff to contact _____to schedule.

[ ] Additional medical information required:

[ ] Patient advised by OMS clinician:

[ ] Staff to advise patient:

[ ] Accommodation requested is appropriate:

[ ] Accommodation requested does not meet medical condition for ADA criteria:

[ ] Accommodation cannot be expected to allow patient to perform Essential Job Functions:

Clinical Staff Signature: _____ Date: _____