GENERAL INFORMATION

MEDICAL AND PHYSICAL EXAMINATION PROGRAM (MAPEP)

Inquiry Authority/Use Statement

The collection of this information is authorized by O.C.G.A. 45-2-40. This information will be used to determine fitness for duty and to provide protection to employees from potential harmful effects associated with this employment. Unless otherwise stated, this information may be disclosed to the hiring agency, State agencies responsible for State benefits and workers' compensation programs, and, where pertinent, to an appropriate law enforcement agency for investigation for prosecutive purposes or in a legal proceeding to which the hiring agency is a party. As provided by the Americans With Disabilities Act of 1990 (Public Law 101-336), this information is to be filed separately from other personnel records and is to be used only for legitimate, non-discriminatory hiring and placement purposes with reasonable accommodation, where appropriate. Completion of this form is voluntary; however, if this information is not provided, the individual may not receive the requested benefits or employment.

A: Completed by Appointing or Referring Office

(Type or Print in Ink)

1. Employee Name:____
Last, First Middle

2. ____________________
Social Security Number

3. Race ____________________

4. Sex: ❑ Male ❑ Female

5. ____________________
Date of Birth

6. ____________________
Daytime Telephone Number

7. Address: ____________________________________
____
____

8. Position Title: ____________________________

9. Position Number: ____________________________

10. Location of Position:

a. Dept.____________________________________

b. Unit ____________________________________

c. Address ____________________________________
____
____

11. Name of Direct Contact for Position Information: ______________________

12. Title of Direct Contact: ____________________________

13. **a**. Voice telephone number of Direct Contact:____________________

b. E Mail ____________
if available

c. FAX number of Direct Contact ____________________
if available

14. Indicate type of job information used for medical review (check all that apply):

- ❑ Job description
- ❑ Performance standards
- ❑ Functional requirements analysis
- ❑ Environmental factors analysis
- ❑ Other (please specify) _________
  ____
  ____
  ____

15. Check job category:

- ❑ Category 1 Sedentary
- ❑ Category 2 Active
- ❑ Category 3 Food Handling
- ❑ Category 4 Health-related
- ❑ Category 5 Law Enforcement

16. Describe any notable or unusual job requirements or working conditions: (continue on separate page, if needed)

____
____
____
____
____
____

17. Were any "reasonable accommodations" needed? If "Yes," describe: ❑ Yes ❑ No
(continue on separate page, if needed)

____
____
____
____
____
____

18. ____
(Type or Print Official Contact's Name)

19. ____ **20**. ____________________
Signature of Official Contact Date

B: Completed by Applicant/Employee

(Type or Print in Ink)

1. Have you been provided detailed information on the duties of this position? ❑ Yes ❑ No

2. Do you understand the functional requirements and environmental factors of this position? ❑ Yes ❑ No

3. Are you capable of performing the duties and responsibilities of this position (with reasonable accommodations, if necessary, as described in Section A, Item #17)? ❑ Yes ❑ No

For the following questions, explain a "Yes" answer in the space provided below.

4. Have you ever been employed by the State of Georgia? ❑ Yes ❑ No

5. Have you had a physical examination for employment with the State of Georgia within the past twelve months period? ❑ Yes ❑ No

6. Is there anything in your past medical history, of which you have knowledge, that would prevent your being able to perform the duties of this position? ❑ Yes ❑ No

Explanation of items 4-6 checked "Yes." Enter item number before each comment.

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____
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____
____

I certify that all information given by me in connection with this medical assessment is true to the best of my knowledge and belief. I agree and understand that any misstatements of material facts may cause forfeiture on my part of all right to employment in the service of the State of Georgia; may result in dismissal after appointment; or may result in loss of entitlement to disability retirement benefits. My signature also indicates that I understand all of the questions on this form.

7. ____ 8. ____________________
Signature of Employee Date