UNITED STATES POSTAL SERVICE®

Applicant Medical Questionnaire

Name: *(Please Print)*	Telephone No. *(Include area code.)*
Position Offered:	Location:

A. Instructions

Please review the Privacy Act Statement, and then answer each question. If you are not sure of the appropriate response, answer *YES.* Do not provide additional information regarding your medical history on this form. You will have the opportunity to discuss all *YES* responses with a medical professional.

B. Privacy Act Statement

Your information will be used to determine your suitability for the position to which you are being assigned and if necessary how best to accommodate your disabilities. Collection is authorized by 39 U.S.C. 401, 1001, 1005, and 1206.
Providing the information is voluntary, but if not provided, your assessment will not be processed. We may disclose your information as follows: in relevant legal proceedings; to law enforcement when the U.S. Postal Service (USPS) or requesting agency becomes aware of a violation of law; to a congressional office at your request; to entities or individuals under contract with USPS; to entities authorized to perform audits; to labor organizations as required by law; to federal, state, local or foreign government agencies regarding personnel matters; to the Equal Employment Opportunity Commission; and to the Merit Systems Protection Board or Office of Special Counsel; and to your private treating physician and to medical personnel retained by the USPS to provide medical services in connection with your health or physical condition related to employment. For more information regarding our privacy policies visit *usps.com/privacypolicy.*

C. Questionnaire

YES	NO		
☐	☐	1.	Do you have any physical or mental condition or medical limitations that could interfere with your ability to perform the full duties of the job you have been offered?
☐	☐	2.	Are you currently being treated by a medical provider for any health condition or taking any medication that may impair your ability to perform the full duties of the job you have been offered?
☐	☐	3.	Do you now have or have you in the past 2 years had work restrictions imposed by a treating provider that could affect your ability to perform the full duties of the job you have been offered?

D. Certification

I certify that my responses to the questions above are correct to the best of my knowledge and belief. A false or dishonest answer to any question may be grounds for withdrawal of the offer of employment or grounds for termination after appointment.

Applicant's Signature	**Date** (MM/DD/YYYY)