

10-31-2011

## 4.105:01 Medical Examination Consent Form

Follow this and additional works at: [http://aura.antioch.edu/policy\\_forms](http://aura.antioch.edu/policy_forms)

---

### Recommended Citation

"4.105:01 Medical Examination Consent Form" (2011). *999.x Policy Forms*. Paper 13.  
[http://aura.antioch.edu/policy\\_forms/13](http://aura.antioch.edu/policy_forms/13)

This Article is brought to you for free and open access by the Antioch University Policies at AURA - Antioch University Repository and Archive. It has been accepted for inclusion in 999.x Policy Forms by an authorized administrator of AURA - Antioch University Repository and Archive. For more information, please contact [dpenrose@antioch.edu](mailto:dpenrose@antioch.edu), [wmcgrath@antioch.edu](mailto:wmcgrath@antioch.edu).

**FORM # 4.105:01**



**Medical Examination Consent Form**

**Note to applicant:**

The position for which you are applying is one in which candidates who have received conditional job offers are required to have a medical examination. Medical examinations are an important part of the selection process. Information provided by this report will be released only to authorized persons involved in the employment decision.

Antioch University is committed to making all reasonable accommodations necessary to comply with the ADA.

*To be filled out by the applicant after the conditional job offer has been made:  
Title of the position for which you are applying:*

Full name (please print):  
Street address:  
City, State, Zip:  
Social Security #:

I agree that (Medical Examiner) may release this information to Antioch University (AU) in order to verify that I am able to perform the essential duties of the job. I understand that failure to appear for the medical examination may be considered a rejection of the job. I understand that the medical examination given is solely for the benefit of the AU and not the benefit of me. I understand that I may be referred to my health care provider if further evaluation is needed. I understand that it may occasionally be necessary for (Medical Examiner) to contact my health care providers for job-related medical information. I authorize my current health care provider to release this information to (Medical Examiner).

Employee Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

*To be filled out by Medical Examiner:*

Will the candidate be able to perform the essential functions of the job as outlined in the job description and functional job analysis?

Yes

No

Does the applicant have any physical limitations or restrictions?

Yes

No

If so, please identify.

Will the candidate need any accommodations to perform the essential functions of the job as outlined in the job analysis?

Yes

No

If yes, what accommodations are recommended?

Doctor's Signature \_\_\_\_\_

Date: \_\_\_\_\_

Doctor's Name (please print): \_\_\_\_\_

*Instructions for Medical Examiner:*

Please return the completed form to the following address at Antioch University:

(address)

