Consolidated Rail Corporation – Medical Services
Three Commercial Place, Norfolk, VA 23510-9202
Exam forms - Fax 678-512-5090
Custody & Control form - Fax 678-512-5056
Telephone 800-552-2306

HEALTH QUESTIONNAIRE FOR NON-MEDICAL ABSENCES OF ONE YEAR OR LONGER

(e.g., Furlough, Military leave, Discipline, Leave of Absence)

To the employee:

Please complete sections A through D, and fill in your name/Employee ID number on top of page 2. Forward the completed questionnaire directly to the Conrail Medical Department by:

- **Fax to # 678-512-5090** or **Email to physicals@nscorp.com**
- Fax (toll-free) to # 866-627-0592
- Mail to above address

Upon receipt and review of your questionnaire responses, the Conrail Medical Director will evaluate your medical qualification to return to work. When a determination is made that you are medically qualified, the Conrail Medical Department will notify your supervisor to allow you to promptly return to work.

A. EMPLOYEE INFORMATION

Name (Print) Last________________________________First__________________________Middle Initial_____

Home Address_________________________________City____________________State_____Zip__________

Employee ID No.____________________ Date of Birth:____/____/_____ Job title ______________________

Phone No: Work____________________ Home_______________________ Cell_________________________

Preferred method of contact: (check one) _____Email* _____Phone _____Either email or phone

*Email address if preferred method of contact:

B. SUPERVISOR INFORMATION

Supervisor's Name_____________________________Title___________________Department_____________

Supervisor's Phone No. Location (City/State)

C. HISTORY: Please respond to the questions below for the time period during your recent non-medical leave of absence, unless a shorter period is specified.

1. **Do you currently use or have you used illicit drugs? ☐NO ☐YES. IF YES,** describe drug(s), frequency of use and when last used: ____

2. **If you have consumed alcohol: "When was your last alcoholic drink?"** _____________ and **"How often do you drink alcohol?"** Approximately (enter #) ___________drinks per (enter day, week, etc.) ________________.

3. **Have you filed a claim (including worker's compensation) or lawsuit because of an illness or injury? ☐NO ☐YES. IF YES**, specify date, and the related illness or injury: ______________________________

4. **Are you now drawing, or have you applied for, disability benefits – including VA, RRB, SS and/or LHWCA? ☐NO ☐YES. IF YES**, specify any related disabilities and date: ______________________________
____

5. **Have you been denied or removed from employment, or been discharged from military service for medical reasons? ☐NO ☐YES. IF YES**, specify date of denial, removal or discharge, and medical reason:
____

6. **Have you taken any over-the-counter medication and/or supplements in the last 30 days?**
☐NO ☐YES. IF YES, PLEASE LIST: ____
____
____
____

Employee Name (Print):Last_______________________First_______________ MI___
Employee ID No.: ________________________________

C. HISTORY (continued): PLEASE COMPLETE THE CHART BELOW BY ANSWERING – During your recent non-medical leave of absence, have you had or do you now have any of the following?

If answer is yes, check "Y" box, provide date diagnosed and explanation.
If answer is no, check "N" box. If you do not know, write "Don't know".

	ITEM	Y	N	DATE	CONDITION/EXPLANATION
1	Loss of or impaired memory, alertness or concentration				
2	Loss of consciousness/fainting spell/vertigo or dizziness				
3	Epilepsy, seizure or "fits"				
4	Head/Brain injury or neurological disorder (stroke, transient ischemic attack, concussion, etc.)				
5	Numbness, weakness or paralysis				
6	Migraines/Headaches requiring prescription medication				
7	Sleep disorder or problem (sleep apnea, insomnia, narcolepsy, etc.)				
8	High blood pressure				
9	Heart disease/rhythm problem, heart attack, chest pain/angina, heart surgery/procedure (stents, CABG, pacemaker/AICD implantation, etc.)				
10	Diabetes				
11	Kidney disease				
12	Asthma or other lung problem (short of breath, cough…)				
13	Neck or back injury/pain/condition				
14	Shoulder, arm, elbow, wrist or hand injury/pain/condition				
15	Hip, leg, knee, ankle or foot injury/pain/condition				
16	Broken bones (cracked / fractured)				
17	Swollen and/or painful joints (arthritis, gout, etc.)				
18	Missing / impaired arm, hand, finger, leg, foot, toe				
19	Eye disorder /impaired vision (other than corrective lenses)				
20	Ear disorder or impaired balance or hearing (other than hearing aids)				
21	Mental health diagnosis (depression, anxiety, ADD, ADHD, PTSD, drug/alcohol dependence/abuse, etc.)				
22	Hospitalization or Surgical procedure				
23	Allergies (dust, coal tar, bees, etc.)				
24	Other medical conditions, illnesses and/or injuries not specified above.				

D. RELEASE, VERIFICATION AND DISCLOSURE STATEMENT: CAREFULLY READ THE FOLLOWING STATEMENT & SIGN BELOW.

I certify that the answers given herein are true and complete to the best of my knowledge. I authorize release of this information to my employer and whatever investigation is deemed necessary to confirm statements contained in this report of medical examination. **If it is determined, through investigation or otherwise at any time, that any answers are untrue or misleading, or material information is omitted, I understand my employment may be terminated.**

Employee signature: ______________________ **Date signed:** ____________