Elohim Medical Staffing Agency, Inc.

RISK ASSESSMENT FORM

Employee Name_____**Position Applied for**_____

Please Answer the Questions below and return this Questionnaire to Elohim Homecare. (If "Yes" please give explanation on comment line below).

		Yes No	Yes	No	Unknown
1	Have you ever had any illness that may have been caused by or made worse by your work?				
2	Do you consider yourself as having disability? If yes, do you need any adjustments or modifications to do the job you have applied for?				
3	Have you ever had Active, Untreated Tuberculosis?				
4	Any disease associated with severe immunologic deficiency?				
5	Have you ever had HIV or any other STD?				
6	Have you ever had Epilepsy, seizures, sudden unexplained dizziness or loss of consciousness				
7	D o you have difficulty bending, standing, lifting or any other movements				
8	Have you ever had any mental illness or psychological problems including depression, anxiety, schizophrenia etc.				
9	Have you ever had any drug or alcohol related problems				

Comments:

_____

_____ **Do you currently have:**

1) Unexplained fever (Y) (N)
2) Unexplained weight gain or weight loss? (Y) (N)
3) Unexplained fatigue of malaise (Y) (N)
4) Night Sweats (Y) (N) communicable diseases in the past year (Y) (N)
5) Unexplained loss of appetite (Y) (N)
6) Cough lasting more than 3 weeks(Non related to Viral upper infection or chronic lung disease) (Y) (N)
7) Coughing up blood (Y) (N) (More than 3 weeks)

2815 100th St #386 Urbandale, IA 50322

www.elohimhcs.com Email: info@elohimhcs.com Phone: (515) 999-7701 or (515) 599-3399

FAX: 515-257-7260

8) Any exposure to tuberculosis or any other

Comments:

_____

_____

I certify that I have read this document answered all the questions to the best of my Knowledge and Ability.

2815 100th St #386 Urbandale, IA 50322

www.elohimhcs.com Email: info@elohimhcs.com Phone: (515) 999-7701 or (515) 599-3399

FAX: 515-257-7260