

MEDICAL AND PHYSICAL EXAMINATION PROGRAM (MAPEP)

Subsequent Injury Program

This checklist contains questions regarding your medical history and health. This information is requested in compliance with O.C.G.A. 34-9-361. The primary use of this information will be to establish the eligibility of your employing agency to make claims under the Subsequent Injury Trust Fund Laws. It may also be used to determine fitness to perform job duties. This information will be handled in a confidential manner. It is essential that you answer all questions truthfully and completely. False or incomplete information may result in disqualification or termination if hired.

Completed by Applicant/Employee

(Type or Print in Ink)

Section I

Date: _____	
Employee Name: _____	Social Security Number _____ - _____ - _____
Last, First Middle	
Employing Agency: _____	Date Employed: _____

Section II

Have you now, or ever had the following?	Yes	No		Yes	No
1. Loss of sight of both eyes. Loss of uncorrected (without glasses or contact lens) vision of more than 75% bilaterally (vision of 20/160 or J* or worse using both eyes).	<input type="checkbox"/>	<input type="checkbox"/>	14. Psychoneurotic disability following confinement for treatment in a recognized medical or mental hospital for a period in excess of six months.	<input type="checkbox"/>	<input type="checkbox"/>
2. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	15. Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
3. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	16. Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>
4. Epilepsy (convulsions, seizures or fits)	<input type="checkbox"/>	<input type="checkbox"/>	17. Cardiovascular (heart or blood vessel) disease	<input type="checkbox"/>	<input type="checkbox"/>
5. Ankylosis (immobility) of major weight bearing joints (ankles, knee, hip)	<input type="checkbox"/>	<input type="checkbox"/>	18. Total occupational loss of hearing (loss of over half of hearing in each ear)	<input type="checkbox"/>	<input type="checkbox"/>
6. Any permanent condition which causes 20% (or more) impairment of a foot, leg, hand, arm, back, or the body as a whole	<input type="checkbox"/>	<input type="checkbox"/>	19. Compressed air sequelae (damage to lungs, ruptured ear drum, etc to air concussion, blasting, explosion, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
7. Arthritis which is a hindrance to employment	<input type="checkbox"/>	<input type="checkbox"/>	20. Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
9. Amputated (loss of) foot, leg, arm, or hand	<input type="checkbox"/>	<input type="checkbox"/>	21. Hyperinsulinism (hypoglycemia)	<input type="checkbox"/>	<input type="checkbox"/>
10. Parkinson's disease (Paralysis Agitans)	<input type="checkbox"/>	<input type="checkbox"/>	22. Residual disability from poliomyelitis (Disability due to polio)	<input type="checkbox"/>	<input type="checkbox"/>
11. Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>	23. Ruptured intervertebral (back) disc	<input type="checkbox"/>	<input type="checkbox"/>
12. Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	23. Chronic osteomyelitis (bone infection)	<input type="checkbox"/>	<input type="checkbox"/>
13. Mental retardation (intelligence quotient within the lowest two percent of the general population)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

REMARKS: _____

Signature of Employee

Date