Norfolk Southern Corporation – Health Services
Norfolk Southern Railway Company
650 W Peachtree St NW, Atlanta, GA 30308

HEALTH QUESTIONNAIRE FOR NON-MEDICAL ABSENCES OF SIX MONTHS 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 3. Forward the completed questionnaire directly to Norfolk Southern Health Services by:

Email: Notifyhealthservices@nscorp.com

OR

Fax: 470-463-5081

Upon receipt and review of your questionnaire responses, Norfolk Southern Health Services will evaluate your medical qualification to return to work and notify you if additional testing is required. When a determination is made that you are medically qualified, Health Services 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. CURRENT 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 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 prescription medication, over the counter 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 ofthe 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 injuryor 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 inj ury/pain/condition				
14	Shoulder, arm, elbow, w rist or handinj ury/pain/condition				
15	Hip, leg, knee, ankle or foot injury/pain/condition				
16	Broken bones (cracked / fractured)				
17	Sw ollen and/or painful joints (arthritis, gout, etc.)				
18	Missing / impaired arm, hand, finger, leg, foot, toe				
19	Eye disorder /impaired v ision (other than correctiv e 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 inj uries not specified abov e.				

D. RELEASE, VERIFICATION AND DISCLOSURE STATEMENT: CAREFULLY READ THEFOLLOWING 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:** _____