



CBI Health Informed Consent for Functional Testing and Release of Medical Information For participation in BCEHS Post Offer Employment Test (POET).

I hereby provide my written informed consent to participate in this physical/functional assessment in order to determine my physical abilities. My signature on this form indicates my understanding of the information provided and my voluntary consent to proceed with the testing protocol.

I understand that the activities are designed to place a gradually increasing workload on the musculoskeletal and cardiorespiratory systems. There is a risk of certain changes that might occur during or following the testing. These changes might include abnormalities of blood pressure or heart rate. I understand that I am responsible for monitoring my own condition throughout the testing process and should any unusual symptoms occur, I would cease my participation and inform the evaluator of the symptoms.

If I am unable to perform any of these activities due to a disability, I understand that it is my responsibility to advise my evaluator of the need for accommodation in the testing process. The administration of the test may be delayed in order to make appropriate arrangements for accommodation and to obtain the verification of the disabling factors that need to be taken into consideration.

I understand that a summary of the test results will be sent to BCEHS within 24 hours. I hereby give consent to the transmission of this information by telephone, fax, e-mail or mail as required by BCEHS.

In the event that a medical clearance must be obtained prior to my participation in the testing program, I agree to the contact of my physician by BCEHS, or its designated agents (i.e. the CBI Workplace Solutions / CBI Health Group) in order to obtain written permission from my physician prior to the commencement of the testing program. I also agree to the release of medical records related to the determination of my ability to safely participate in the testing process.

In consideration of my desire to participate in the BCEHS functional assessment, I agree to assume the risk of such activities required to determine my suitability for the essential job functions. I further agree to hold harmless BCEHS and CBI Workplace Solutions / CBI Health Group and its staff members conducting the testing program from any and all claims, suits, losses, or related causes of action for damages, including, but not limited to such claims that may result from my injury or death, accidental or otherwise, during, or arising in any way from the test activities.

Signature of Participant: _____ Date: _____

Name: _____ Date of Birth: _____

Address: _____
(street) (city) (province) (postal code)

Telephone Number: (home) _____ (work) _____

Signature of Witness _____ Date: _____

Name of Family Physician: _____ Telephone Number: _____

Physician's Address: _____
(street) (city) (province) (postal code)

