Job Specific Testing (JST)-Physical Demand Testing Consent Form

Candidate: _____ Date: _____

By placing my signature upon this document, I hereby agree to participate in a physical capacity test to be conducted at Select Physical Therapy. This test has been requested by the St. Lucie Public Schools as a condition of my placement with the St. Lucie Public Schools. I understand that I am not obligated by Select Physical Therapy or St. Lucie Public Schools to participate, but I cannot be placed or transferred, as the case may be, if I do not participate. I acknowledge and consent that the St. Lucie Public Schools will have access to the information collected and the results of this test. _____ (INT.)

I hereby authorize Select Physical Therapy to release complete information acquired in the course of this Employment Testing to authorized representatives of the St. Lucie Public Schools, including their insurance carrier or its representatives, at the request of the St. Lucie Public Schools or their insurer. _____ (INT.)

I understand that, as a part of this test, I may be requested to perform tests which will enable the medical staff to assess and evaluate my posture, flexibility, strength, lifting capacity, and other anticipated job-specific tasks that have been described to me by Select Physical Therapy personnel. I understand that these tests will be administered by licensed health care providers, and by trained personnel of their choice under the direction of the licensed medical staff. I understand that the test follows safe, established protocols and that the staff is trained to safely provide and monitor the testing procedures. I agree to follow all instructions given to me during the testing process, and to notify the therapist or technician if I do not understand the instructions. I understand that it will be necessary to put forth my good safe effort during testing and feel as if I am able to do so. _____(INT.)

I acknowledge that the performance of this physical capacity test will entail certain risks and physiological changes that could cause light-headedness, fainting, musculoskeletal injury, back discomfort, shortness of breath, and in extremely rare cases palpitations, heart attacks, or more serious complications. _____ (INT.)

I agree to notify the therapist or technician if I feel any pain or discomfort in the performance of the test. I understand that the test may be discontinued at any time due to signs of discomfort or feelings of faintness. I further agree to hold Select Physical Therapy, WorkSTEPS® and the St. Lucie Public Schools harmless, except with proof of negligence, if I do incur any injury during the testing procedures. _____ (INT.)

I have been given an opportunity to ask questions about my present physical condition and about the physical tests to be performed, and I believe that I have sufficient information to give this informed consent. I certify that I have been advised of my right to request any reasonable accommodation needed because of a disability and that I have no medical or other conditions or limitations to my performing these physical tests. _____ (INT.)

I certify that this form has been fully explained to me, that I have read it or had it read to me, that the blank spaces have been filled in by me, and that I understand its contents. _____ (INT.)

Signature _____Date_____

Signature of Witness _____Date _____

Consent To Taking Of Photographs I hereby authorize Select Physical Therapy and associates or assistants to take photographs of me as a part of the requested testing. Photographs are taken by the WorkSTEPS® provider for identification purposes only, and only in the instance that the candidate cannot provide an acceptable form of photo identification to insure the appropriate person is being tested by the provider Select Physical Therapy. _____ (INT.)