Transamerican Auto Parts Company, Inc.
ProCompetition Tire and Wheel Company, Inc.
4 Wheel Parts Wholesalers, Inc.
United Web Sales, Inc.

Conditional Job Offer and Medical Review

Applicant Note: This form is to be completed ***only*** after you have been given an offer of employment.

_____ _____ _____
Applicant Name **Position** **Date of Job Offer**

Based on qualifications presented on your application form and/or in your job interview, you are hereby offered a job with our organization conditional upon submitting to our standard medical review and the verification of your answers to the following questions. Your job offer cannot and will not be rescinded unless a medical review reveals that you cannot perform the essential functions of the job (with accommodations, if requested) or you present a hazard to yourself or others. False or misleading statements are also grounds for rescinding this offer. Please note that workers' compensation benefits in some states may be affected by false or misleading information. This form must be accurate and complete for us to process. This information is considered personal and medical in nature will be treated as such by handling it confidentially in strict compliance with the American with Disabilities Act. This offer is valid only if a company representative signs the bottom of this page.

EMERGENCY INSTRUCTIONS

In case of Emergency Contact

_____ _____
Name **Phone Number**

_____
City / State

Are there any other emergency instructions, circumstances, medical needs, allergic responses or procedures the company should know?

(CONTINUE IN COMMENT SECTIN ON BELOW IF NECESSARY)

HEALTH AND SAFETY

I. Have you ever had any injuries on the job? ☐YES ☐NO
If yes please describe:

	1	2	3
Date of Injury			
Employer			
Body Part Affected			
Cause			
Amount of Time Lost			
Any Permanent Disability (%)?			
Was Worker's Comp Claim Filed?			

(If applying for a job in NY or IL, leave worker's comp question, line g, blank)

COMMENTS:

AFFIRMATION AND AUTHORIZATION

I hereby affirm that the information on this form is true and correct, and that there are no omissions, false information, or misrepresentation of facts. I authorize any physician, medical facility, law enforcement agency, administrator, state agency, institution, information service bureau, insurance company or employer contacted by this company or agent of this company to furnish or verify worker's compensation information and medical records.

I further acknowledge that a telephone facsimile (FAX) or photographic copy shall be as valid as the original.

_____ _____
TODAY'S DATE SIGNATURE

Upon successful completion of this review you will be given a formal offer.

FOR EMPLOYER USE ONLY

VERIFICATION (Human Resource Representative): _____ _____
Initials Date

COMMENTS

Personal and Confidential
This page contains sensitive information, store in secure "medical only" files, separately from personal records!