NORFOLK SOUTHERN CORPORATION / MEDICAL SERVICES
NORFOLK SOUTHERN RAILWAY COMPANY
THREE COMMERCIAL PLACE, NORFOLK, VA 23510-9202
Telephone (800) 552-2306

HEALTH QUESTIONNAIRE FOR EMPLOYEES RETURNING TO WORK FROM NON-MEDICAL ABSENCES OF ONE YEAR OR LONGER

(e.g., Furlough, Military leave, Discipline, Leave of Absence)

***To the employee*: please complete this health questionnaire for the time period during your recent non-medical leave of absence. Please forward the completed questionnaire directly to the Norfolk Southern Medical Department (see bottom page 2). Upon receipt and review of your questionnaire responses, the Norfolk Southern Medical Director will evaluate your medical qualification to return to work. When a determination is made that you are medically qualified, the Norfolk Southern Medical Department 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_____
Business Phone No._____Home Phone No. _____Date of Birth_____
Employee ID No._____ Present Occupation_____
Email address:

B. SUPERVISOR INFORMATION:

Supervisor's Name_____Title_____Department_____
Supervisor's Phone No.: Location (City/State)

C. For every item in the chart below, please respond to the following question (by checking "Yes" or "No" or write "Don't Know"). For the time period of your recent *non-medical absence*, have you had or do you now have any of the following?

	ITEM	YES	NO	#	ITEM	YES	NO
1	Head / Brain injury or disorder (e.g., stroke, concussion…)	○	○	17	Neck or back injury/pain/condition	○	○
2	Numbness, weakness or paralysis	○	○	18	Shoulder, arm, elbow, wrist or hand injury/pain/condition	○	○
3	Epilepsy, seizure or "fits"	○	○	19	Hip, leg, knee, ankle or foot injury/pain/ condition	○	○
4	Loss of consciousness, fainting spell, vertigo or dizziness	○	○	20	Missing or impaired arm, hand, finger, leg, foot or toe	○	○
5	Loss of or impaired memory, alertness or concentration	○	○	21	Swollen and/or painful joints (e.g., arthritis, gout…)	○	○
6	Migraines / headaches requiring prescription medication	○	○	22	Skin rash or condition (e.g., eczema, psoriasis, etc…)	○	○
7	High blood pressure	○	○	23	Allergies (e.g., dust, coal tar, bees, etc…)	○	○
8	Heart disease or heart rhythm problem, heart attack, chest pain/angina, heart surgery/procedure (e.g, stents, cath., …)	○	○	24	Sleep disorder or problem (e.g., sleep apnea, insomnia, narcolepsy, etc…)	○	○
9	Diabetes, Thyroid/Addison's disease or Cushing's syndrome	○	○	25	Eye disorder / impaired vision (excludes corrective lenses)	○	○
10	Asthma or other lung problem (e.g., short of breath, cough...)	○	○	26	Ear disorder or impaired balance or hearing (excludes hearing aids)	○	○
11	Tuberculosis or other infectious disease	○	○				
12	Stomach/digestive problems; liver or kidney disease	○	○	27	Mental health/ psychiatric diagnosis, treatment or medication use for (e.g., depression, anxiety, attention deficit disorder, post-traumatic stress disorder, drug or alcohol dependence/abuse, (etc.)	○	○
13	Anemia or other blood disorder	○	○				
14	Cancer or Tumor	○	○				
15	Hospitalization or Surgical procedure	○	○				
16	Broken bones (cracked/fractured)	○	○	28	Other medical conditions, illnesses or injuries	○	○

Employee Name (Print):Last_____ First _____ MI____
Employee ID No.: _____

PLEASE EXPLAIN ANY "YES" ANSWERS NOTED IN THE CHART ABOVE:

PLEASE LIST ALL MEDICATIONS (INCLUDING PRESCRIBED / NON-PRESCRIBED MEDICATION(S) AND SUPPLEMENTS) TAKEN IN THE LAST 30 DAYS:

PLEASE ANSWER THE FOLLOWING QUESTIONS:

(1) Have you used tobacco (including smokeless)? ☐ Yes ☐ No. If "Yes", how much over what time period (e.g., # packs smoked per day, week…, & # years smoked) and when last used? _____.

(2) Have you consumed alcohol? ☐ Yes ☐ No. If "Yes", (a) describe when last used _____ and (b) describe approximate amount/frequency of alcohol use: _____(specify: # of drinks) per _____(e.g., day, week, weekend…)

(3) Do you use or have you used illicit drugs? ☐ Yes ☐ No. If "Yes", describe drug(s), frequency of use and when last used: _____

(4) If the purpose of your leave was military leave, have you been discharged from military service for medical reasons? ☐ Yes ☐ No If yes, specify date of denial, removal or discharge, and medical reason: _____

(5) Have you filed a claim or lawsuit because of an illness/injury (including a worker's compensation claim)? ☐ Yes ☐ No If yes, specify date, illness/injury _____

(6) Are you now drawing or have you applied for disability benefits (including Social Security, VA, Longshore and/or RRB)? ☐ Yes ☐ No. If yes, specify disability(ies)_____

RELEASE, VERIFICATION AND DISCLOSURE STATEMENT: PLEASE READ THE FOLLOWING STATEMENT CAREFULLY AND SIGN BELOW.

I certify that the answers given herein are true and complete to the best of my knowledge. I authorize whatever investigation is deemed necessary to confirm statements contained in my responses to this questionnaire. **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.**

Signature of Employee: _____ Date signed:_____

Please forward the completed questionnaire directly to the Norfolk Southern Medical Department:

Preferred method	**FAX TO # 678-512-5090**
Other methods	• **Fax (toll-free) to: # 1-866-627-0592** • **Mail to: Norfolk Southern Corporation, Three Commercial Place, Norfolk, VA 23510-9202** • **Email to:** medicalrecords@nscorp.com