



Exhibit D

MEDICAL HISTORY FORM

Name (Last, first, middle)	Social Security Number	Date of Birth
Address (including zip code)	Job Title	Sex

- Elaborate on each "YES" answer in the Remarks Section on the back of this form.**
- | | | |
|---|--------------------------|--------------------------|
| | NO | YES |
| 1. Have you ever worked for Alaska Railroad Corporation (ARRC)? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, date of employment: _____ Last physical exam: _____ | | |
| 2. Have you ever been rejected for employment, Armed Services, or insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever requested or received benefits, pension, or payment because of an injury, sickness, or disability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you under treatment for any medical condition at this time? List medication(s) below. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Were you a member of the Armed Services? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. List injuries, operations, serious illnesses, and dates: _____ | | |

Have you ever been treated for or had any known indication of: (Each "YES" must be explained in the Remarks Section)

	NO	YES		NO	YES
Head injury, concussion, unconsciousness?			Diabetes, thyroid, or other endocrine disorder?		
Epilepsy or convulsions?			Allergies, drug sensitivities, anemia?		
Dizziness, fainting, headache, paralysis, stroke, speech defect, or other mental/nervous disorder?			Disorder of skin, lymph glands, immune system, or cancer?		
Eye trouble (except for glasses)?			Do you smoke? (How many per day? _____)		
Ear problems or deafness?			Tuberculosis: last TB test: _____ Positive <input type="checkbox"/> Negative <input type="checkbox"/>		
Chest pain, palpitation, high blood pressure, heart murmur, rheumatic fever, heart attack, or other disorder of the heart or blood vessels?			Arthritis, muscular disorder, sciatica, gout, neuritis, rheumatism, or any disorder of muscles or bones, including the spine, back or joints?		
Shortness of breath, persistent hoarseness/cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis, or other chronic respiratory disorder?			Family history of TB, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness, or suicide?		
Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestine, liver or gallbladder?			<u>Males Only:</u> Have you had any disease or disorder of the prostate or reproductive organs?		
Sugar, albumin, blood or pus in urine, stone, or other disorder of kidney or bladder?			<u>Females Only:</u> Have you ever had any disorder of menstruation or pregnancy?		
Have you ever been treated, counseled, or joined a support group because of alcohol or drug abuse?			Have you had any disease or disorder of the breast or reproductive organs?		
Have you ever been treated for back problems?			Are you pregnant?		

(OVER)

Remarks Section:

To Alaska Railroad Corporation (ARRC) Employee/Applicant:

The ARRC needs certain limited medical information about you to ensure that you are capable of performing the position you hold with the ARRC or the one for which you are applying. Medical information outside the scope of that need-to-know is not obtained by the ARRC. Although the ARRC may have limited access to certain relevant information in your medical files, the files themselves are not kept at the ARRC, nor are they fully accessible by ARRC personnel. All medical information kept by the ARRC and the ARRC’s contract physicians is maintained in a strictly confidential manner.

Bearing that in mind, please certify the following:

I certify that the information I have provided on this form and will provide to medical staff is true and correct. I understand that making false statements in connection with this form or this examination constitutes just cause for my discharge from the ARRC or, if I am not yet employed by the ARRC, for withdrawing the conditional offer of employment that has been made to me. I hereby authorize the release of all medical information, including medical records, relevant to my physical and mental ability to perform the job requirements of the position that I hold, or for which I am applying, with the ARRC. This release extends to the ARRC and to its contract physicians.

Applicant / Employee Signature: _____

(Please print your name)

Date: _____