

## EMPLOYEE PHYSICAL FORM - TO BE COMPLETED BY PROVIDER

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

### Physical Findings

Height:	Weight:	General Appearances:
Blood Pressure:	Pulse	Respiration:
Heart:	Lungs:	
G.I.:	Musculoskeletal:	
Current Medications:		

### Test/Lab Results (\*\* Test/Lab Results are only required upon hire\*\*)

**PPD (Mantoux) Results:		Attach Documentation	
**PPD 2 (Mantoux) Results:		Attach Documentation	
**Chest X-Ray if PPD Positive: Documentation	Date Read:	Results:	Attach
**Quantiferon TB Gold Test: Documentation	Date Given:	Results:	Attach
**MMR (Measles, Mumps, Rubella) Attach documentation - Lab Report			
1. Proof of immunity with titers <b>OR</b> 2. Proof of 2 doses as proof of immunization			
**4 Panel Drug Screen Results Attach Documentation			
Influenza Vaccine:	Lot #:		
Date Administration:	Expiration Date:		

Does this patient have any physical limitations: Yes: \_\_\_\_\_ No: \_\_\_\_\_

If Yes, explain any limitations in detail: \_\_\_\_\_

**THIS PERSON IS FREE FROM ANY HEALTH IMPAIRMENT WHICH IS OF POTENTIAL RISK TO THE PATIENT OR WHICH MIGHT INTERFERE WITH THE PERFORMANCE OF HIS/ HER DUTIES, INCLUDING THE HABITUATION OR ADDICTION TO DEPRESSANTS, STIMULANTS, NARCOTICS, ALCOHOL OR OTHER DRUGS OR SUBSTANCES WHICH MAY ALTER THE INDIVIDUALS BEHAVIOR.**

Provider's Signature: \_\_\_\_\_

Provider's License Number: \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICAL STAMP

**Please Note:**

*This document must be stamped with provider's official stamp and be accompanied by the required documentation. The physical form will not be accepted without the proper verification.*