Marguerite Connolly Training & Consulting
A LEADER IN HEALTHCARE TRAINING

Applicant Name: _____ Telephone: _____

Address: _____

_____

The following to be completed by a physician

1. Does the applicant suffer from any physical problems, which requires special consideration?
   Yes ☐ No ☐

2. Does the applicant suffer from any physical illness? Yes ☐ No ☐

3. Does the applicant suffer from any chronic emotional illness?
   Yes ☐ No ☐

4. Does the applicant suffer from any communicable disease?
   Yes ☐ No ☐

5. Does the applicant suffer from any skin disease?
   Yes ☐ No ☐

6. Does the applicant suffer from allergies?
   Yes ☐ No ☐

7. Does the applicant suffer from any cardiovascular disease?
   Yes ☐ No ☐

8. Does the applicant suffer from any respiratory disease?
   Yes ☐ No ☐

9. Does the applicant suffer from any musculoskeletal disease?
   Yes ☐ No ☐

10. Does the applicant suffer from any hearing impairment?
    Yes ☐ No ☐

11. Does the applicant suffer from any visual impairment?
    Yes ☐ No ☐

    * if answered yes to any of the above questions, is this person currently receiving treatment?
    Yes ☐ No ☐

12. Does the applicant have any history of drug or alcohol use/abuse?
    Yes ☐ No ☐ * if yes, is this person currently receiving treatment? Yes ☐ No ☐

This is to certify that I have examined _____ on _____, 20__ and deem him/her to be physically/mentally fit to pursue a career as a Resident Care Worker.

Physician Name: _____ Physician Signature: _____