LINCOLN TRADE SCHOOL LTD.

****MUST ATTACH LAB RESULTS****

☐ Pre-Employment Physical Assessment ☐ Annual Assessment ☐ Return to Work/LOA ☐ Other		
Name:	**Marital Status:** ☐ M ☐ S ☐ W ☐ D	**Sex:** ☐ M ☐ F ☐ Other
Address:	**SSN:**	**DOB:**

PHYSICAL EXAMINATION

HEAD/ENT:	HEART DISEASE	☐ Y ☐ N
EYES:	HIGH BLOOD PRESSURE	☐ Y ☐ N
NECK:	BACK PROBLEM	☐ Y ☐ N
CARDIOVASCULAR:	ARTHRITIS	☐ Y ☐ N
LUNGS:	PSYCHIATRIC ILLNESS	☐ Y ☐ N
MUSCULARSKELETAL:	ALCOHOL ABUSE	☐ Y ☐ N
ABDOMEN:	DRUG ABUSE	☐ Y ☐ N
GENITOURINARY:	EPILEPSY/SEIZURES	☐ Y ☐ N
CENTRAL NERVOUS SYSTEM:	ALLERGIES	☐ Y ☐ N
BREASTS:	ASTHMA	☐ Y ☐ N
COMMENTS:		

E: RESP: TEMP:	HEIGHT:	WEIGHT:	BP
TEST	**DATE PERFORMED**	**DATE READ**	**RESULTS** *(PROVIDE LAB VALUES AND INTERPRETATIONS)*
PPD (ANNUALLY)	DATE IMPLANTED	DATE READ	RESULTS *(MMXMM)*
PPD 2ND DOSE	DATE IMPLANTED	DATE READ	RESULTS *(MMXMM)*

CHEST XRAY (+PPD)	**DATE:**	**RESULTS:**

IMMUNIZATIONS	**DATE**	**DATE**	**RESULTS + LAB VALUE**	**RESULT DATE**
Measles/Rubeola	**1**	**2**	☐ IMMUNE	
Rubella	**1**	**2**	☐ IMMUNE	
Varicella	**1**	**2**	☐ IMMUNE	
Mumps	**1**	**2**	☐ IMMUNE	

DRUG SCREEN	**COMMENTS:**

Physician must select one of the following:

☐ This individual is free from any health impairment that is a potential risk to the patient or the other employee which may interfere with the performance of their duties including the habituation or addiction to drugs or alcohol.

☐ This individual can work with the following limitations:

☐ This individual is not physically/mentally able to work (Specify reason):

PHYSICIAN SIGNATURE _____ **LICENSE NUMBER** _____ **DATE** _____

PHYSICIAN STAMP: