PHYSICAL FORM

NAME: ____

Circle appropriate choice: Initial Examination Re-examination

This section to be completed by Health Professional:

Name of Physician: ____

Address: ____

Phone Number: ____

Part 1: Is the individual free from communicable tuberculosis as shown by a negative skin test followed by one negative x-ray and an asymptomatic history of this health appraisal? (CIRCLE ONE) Yes No

If no, please explain, giving plan follow-up. ____

Please include the individual's chest x-ray report

If a 2 step mantoux has previously been completed please provide the recorded date for the 2 steps, as well as any yearly follow-up TB testing dates.

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Part 2: Does this employee have any of the following medical problems

A. Communicable disease? (CIRCLE ONE) Yes No

   If yes, please explain: ____

B. Any special medical problems, prescribed medications, or chronic disease that may require restrictions of activity and/or job duties or that may interfere with the health of a client or which may prohibit the individual from providing adequate care for the clients? (CIRCLE ONE) Yes No

   If yes please explain: ____

PHYSICIAN SIGNATURE: ____ DATE OF EXAM: ___________________

If any additional comments are required, they may be given on the back of this form.

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