Hosana
Home Health Care Services

"Compassionate & Quality Care"

EMPLOYMENT PHYSICAL FORM

NAME_____ **DATE OF EXAM:** _____

THIS SECTION MUST BE COMPLITED BY A HEALTHCARE PROFESSIONAL.

Please answer all questions and provide detailed explanation for all observed symptoms.

DOES PERSON HAVE:	YES	NO	DOES PERSON HAVE:	YES	NO
Less than 20/40 combined vision			Epilepsy		
Abnormal hearing			Diabetes		
Abnormal blood pressure			Inadequate immune system		
Abnormal Cardiovascular system			Need for more sick days than average		
Abnormal respiratory system			Drug and alcohol dependency		
Abnormal neuro musculoskeletal systems			Disabling emotional disorder		
Abnormal endocrine system					

Is this individual free from communicable tuberculosis as shown by: **YES**_____ **NO** _____

TWO STEP PPD TEST

FIRST STEP PPD	SECOND STEP PPD	RESULTS
Date Administered:_____	Date Administered:_____	FIRST STEP:_____
Date read: _____	Date read: _____	SECOND STEP:_____

NOTE: TWO STEP PPD TEST is required according to PA Department of Health for Employment.
IF POSITIVE skin test is indicated:

- Is it followed by one negative x-ray and an asymptomatic history of this health appraisal**? YES**___**NO**___
- Is this individual FREE of any of the following medical problems:
- Communicable Diseases**?** **YES**___**NO**____
- Medical or physical problems that may prohibit or restrict this individual from providing adequate care for ***non* –ambulatory clients**? **YES**____ **NO**____
- Is the individual cleared to work**? YES**____**NO**
- Is this person physically fit to work (capable of lifting up to 50 lbs.)? **YES**____**NO**____

TO BE COMPLETED BY PROVIDING HEALTHCARE PROFFESSIONAL

Date of Exam: _____ Printed Name: _____
Signature_____ License Number: _____
Address: _____
Phone number: _____ Fax Number: _____