HEALTH / PHYSICAL EXAMINATION

Name: _____ Date of Birth: _____

Date of Exam: _____

Height: _____ Weight: _____

Temp: _____ Pulse: _____ Resp: _____ B/P: _____

Clinical Evaluation: (Please Check)

Normal		**Abnormal**
[]	**Head, Eyes, Ear, Nose Throat**	_____
[]	**Lungs & Chest (Include Breast)**	_____
[]	**Heart**	_____
[]	**Abdomen**	_____
[]	**Extremities**	_____
[]	**Neurological**	_____

___ Can lift 50lbs or greater **___Cannot lift 50lbs or greater**

Test	**Date Performed**	**Results**
PPD:		
Chest X-Ray		

Based upon the above physical examination:

[] Patient is in good general health and does not appear to be at risk of transmitting communicable diseases and tuberculosis. Patient is physically qualified for normal duty.

[] Patient's health is questionable and may be at risk of transmitting communicable diseases.

Specify_____

Health Care Provider Information

_____ _____

Health Care Provider M.D. / D.O. / ARNP/ PA (Print) Medical License Number

_____ _____

Signature of Health Care Provider Date

Address: _____

Telephone: _____ Fax: _____