

**ENRICHED HOME CARE AGENCY**

**EMPLOYEE PHYSICAL EXAMINATION REPORT**

<input type="checkbox"/> Pre-Employment Physical Assessment		<input type="checkbox"/> Annual Assessment		<input type="checkbox"/> Return to work/LOA		<input type="checkbox"/> Other:	
Name:			Marital Status : <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D		Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Address:			SS#:		Title:		
<b>PHYSICAL EXAMINATION</b>							
HEAD/ENT:							
EYES:							
NECK:							
BREASTS:							
LUNGS:							
CARDIOVASCULAR:							
MUSCULOSKELETAL:							
ABDOMEN:							
GENITOURINARY:							
CENTRAL NERVOUS SYSTEM:							
<b>COMMENTS:</b> <u>LABORATORY TEST REPORT FOR DRUG SCREEN TEST; RUBELLA, RUBEOLA; CHEST X-RAY based on Positive PPD Or QuantiFERON-TB Gold (IGRA) blood test to screen for tuberculosis MUST BE ATTACHED!</u>							

HT:	WT:	B/P:	PULSE:	RESP:	TEMP:
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**LABORATORY TEST RESULT**

TEST	DATE PERFORMED	RESULTS	
		PROVIDE LAB VALUES AND INTERPRETATION	
RUBELLA TITER		<input type="checkbox"/> NON-IMMUNE	<input type="checkbox"/> IMMUNE    LAB VALUE:
MEASLES TITER		<input type="checkbox"/> NON-IMMUNE	<input type="checkbox"/> IMMUNE    LAB VALUE:
1 <sup>st</sup> STEP PPD	1.DATE IMPLANTED:	1.DATE READ:	RESULTS (mmx mm)
2 <sup>nd</sup> STEP PPD	2.DATE IMPLANTED:	2.DATE READ:	RESULTS (mmx mm)
QuantiFERON-TB Gold (IGRA) blood test	DATE:		RESULT:
CHEST X-RAY (+PPD)	DATE:		RESULT:

IMMUNIZATIONS:	DATE	DATE	DATE
RUBELLA	1.		
RUBEOLA/MEASLES	1.		
HEPATITIS B VACCINE	1.	2.	3.
DRUG SCREEN TEST RESULT			

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

This individual is able to work with the following limitations:

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

PHYSICIAN SIGNATURE:	License No:	Date:
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**STAMP HERE**

