



Employee Health Examination

Last Name: _____ First Name: _____

Age: _____ Date of Birth: ___/___/___ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Position: _____

Consent for examination and release of information:

Signature of Patient: _____ Date: _____

PLEASE DO NOT WRITE BELOW THIS LINE

FOR PHYSICIAN ONLY:

| | WNL (within normal limits) | | Positive Findings/ Comments |
|--------------|----------------------------|--|-----------------------------|
| Head | | | |
| Eyes | | | |
| Ears | | | |
| Nose | | | |
| Mouth/Teeth | | | |
| Neck/Back | | | |
| Chest/Breast | | | |
| Lungs | | | |
| Heart | | | |
| Abdomen | | | |
| Extremities | | | |
| Neuro/Reflex | | | |
| Skin | | | |

Vital Signs: Temp: _____ Pulse: _____ Respiration: _____

Blood Pressure: _____ Height: _____ Weight: _____

Comments: _____

ADVANCED CARE STAFFING

Employee Health Examination

Last Name: _____ First Name: _____

Age: _____ Date of Birth: ___/___/___ Social Security #: _____

PLEASE DO NOT WRITE BELOW THIS LINE

FOR PHYSICIAN ONLY:

U/A: N/A Glucose: _____ Protein: _____ Cells: _____ Other: _____

Rubella Status: Immune Non- Immune
Date: _____ Titer Level: _____

Measles Status: Immune Non- Immune
Date: _____ Titer Level: _____

Mumps Status: Immune Non- Immune
Date: _____ Titer Level: _____

Varicella Status: Immune Non- Immune
Date: _____ Titer Level: _____

Hepatitis Status: Immune Non- Immune
Date: _____ Titer Level: _____

Lab work **MUST be attached*

Tuberculin Skin Testing/ PPD Testing

History of TST- Date Given: ___/___/___ Date Read: ___/___/___ Results: _____

If Positive, Chest X-Ray Date: ___/___/___ (attach report)

If previous negative TST, < 12 month, 1 step TST to be administered:

Manufacturer/Lot #: _____

Date Given: ___/___/___ Date Read: ___/___/___ Results: _____

If no previous TST result or previous result > 12 months, a 2nd step TST to be administered 1-3 weeks after the 1st TST result is read.

Manufacturer/Lot #: _____

Date Given: ___/___/___ Date Read: ___/___/___ Results: _____

If Positive, Chest X-Ray Date: ___/___/___ (attach report)

- Employee may work:**
- Without restrictions
 - With restrictions (specify reason and duration) _____
 - Unable to work (specify reason and duration) _____

Physician Signature: _____ **Date:** _____ **License #:** _____

