EMPLOYEE PHYSICAL EXAMINATION

THIS GENERATION CARES.

Name of Individual Examined: ____

DOB: ______________________ Position Title:_________________________

Purpose of Examination: ___Initial Exam (New Employee) __Re-Examination

Type of Facility: ___ MH Residential ___MR Residential

THIS SECTION TO BE COMPLETED BY HEALTH PROFESSIONAL WHO DOES EXAMINATION

PART I: Explain All "**NO**" Responses on an additional page

As shown by physical examination, does the individual have:	**YES**	**NO**
1. Normal Blood Pressure	________	_________
2. Normal Cardiovascular System	________	_________
3. Normal Respiratory System	________	_________
4. Normal Skin	________	_________
5. Normal Neuro Musculoskeletal System	________	_________
6. Normal Endocrine System	________	_________ _

PART II: Explain All "**YES**" Responses on an additional page

[N.CARTER, 7/2015]

As shown by physical examination, does the individual have:	**YES**	**NO**
7. Communicable diseases? (List)	________	_________
8. Other specific problems or chronic disease which requires restriction of activity, or medication, or which might affect his/her work role? If so specify on reveres.	________	_________
9. Does this individual have any special medical problems which might interfere with the health of the consumer or which might prohibit the individual from providing adequate care for the participates? If "yes" explain on reverse side.	________	_________

PART III: Individual is FREE from Communicable Tuberculosis as Shown by:

10. ___Mantoux Test (PPD) Date Administered:_________ Signature:________________ Title: ________

(Must be Administer Only by MD, RN, or LPN)

Read as: _______ Date: ___________ Signature:____________________ Title: ____________

(Must be Administer Only by MD, RN, or LPN)

TB Screen is NEGATIVE TB Screen is POSITIVE Expiration Date:__________________

11. ____Positive Skin test followed by one negative x-ray and an asymptomatic history at this health appraisal.

Note: Tine Test is NOT acceptable. New employees are required to have TB testing within 6 months prior to start date, thereafter every two years.

Name & Address of Licensed Physician Telephone #

____ _____________________________________

Signature of Above Physician License # Date of Examination

_______________________________________ _____________________ _____________________________