The Ellison Nursing Group, LLC.

Employment Physical Examination Form

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

PATIENT NAME (PRINT): _____

DATE_____

D.O.B_____ **SEX:**_____ **LAST TETANUS DATE:** _____

POSITION TITLE:_____

TO BE COMPLETED BY THE PHYSICIAN ONLY!

1. Past Medical History: _____
2. Current Medications:_____
3. **Is this individual free of Communicable Diseases?: (Please Circle) Yes / No**
4. Previous Hospitalizations?: _____
5. Are there any medical problems which might interfere with the safety or health of the clients?: (Circle) Yes / No
6. Past Injuries : _____
7. **Is the patient able to perform the physical requirements of the job? (Please Circle) Yes / No**
8. History of Substance Abuse? (Please Circle) Yes / No
9. Is there any medical condition that may impact on the employee's driving ability?(Please Circle) Yes / No
10. Any Driving Restrictions?:_____

PPD Test

Date Test Administered (mm/dd/yyyy): _____

Date Test Read (mm/dd/yyyy): _____ Reading/Result: _____

Physician's Name (Print) : _____

Physician's Signature: _____ **Date of Exam:** _____

Physician's Office Address: _____ **City:**_____ **State:** _____

Zip Code: _____ **Physician's License #:** _____

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