PHYSICAL EXAMINATION REPORT

NAME:	DOB:	SSN (Last 4):
ADDRESS:	PHONE:	

	COMMENTS		COMMENTS
HEAD		ABDOMINAL	
EYES		EXTREMITIES	
NECK		CARDIOVASCULAR	
THROAT		MUSCULOSKELETAL	
LUNGS		SKIN	
HEART		CENTRAL NERVOUS SYSTEM	

HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

REQUIRED FOR PRE-EMPLOYMENT

RUBELLA LABS REQUIRED	DATE:	TITER: ☐ IMMUNE ☐ NON-IMMUNE	**MMR VACCINE DATES:** MMR 1:
RUBEOLA (MEASLES) LABS REQUIRED	DATE:	TITER: ☐ IMMUNE ☐ NON-IMMUNE	MMR 2:
PPD	1. Date Implanted:	2. Date Read:	RESULTS (MM): ☐ NEGATIVE ☐ POSITIVE
QUANTIFERON LABS REQUIRED	DATE:	RESULTS: ☐ NEGATIVE ☐ POSITIVE	
CHEST X-RAY LABS REQUIRED	DATE:	RESULTS: ☐ WITHIN NORMAL LIMITS (WNL) ☐ ABNORMAL	
8-PANEL DRUG SCREEN LABS REQUIRED	DATE:	RESULTS: ☐ NEGATIVE ☐ POSITIVE	

TUBERCULOSIS SCREENING QUESTIONNAIRE

1. Chronic Cough	☐ NO ☐ YES	5. Fever	☐ NO ☐ YES
2. Production of Sputum	☐ NO ☐ YES	6. Fatigue/Tiredness	☐ NO ☐ YES
3. Blood-Streaked Sputum	☐ NO ☐ YES	7. Night Sweats	☐ NO ☐ YES
4. Unexplained Weight Loss	☐ NO ☐ YES	8. Shortness of Breath	☐ NO ☐ YES

BASELINE INDIVIDUAL TB RISK ASSESSMENT

Temporary or permanent residence of >1 month in a country with a high TB rate	☐ NO ☐ YES
Current or planned immunosuppression	☐ NO ☐ YES
Close contact with someone who has had infections TB disease since the last TB test	☐ NO ☐ YES

INFLUENZA VACCINE

☐ PROVIDED ☐ DECLINED (Must Sign Declination)	**DATE:**	**LOT#:**

☐ **FREE OF COMMUNICABLE DISEASES**

☐ **FREE OF HABITUATION**

PHYSICAN SIGNATURE:_____ **DATE:**_____

PHYSICAN STAMP:_____ **LICENSE #:**_____

Based on health history provided, physical exam, and/or bab test performed, on this person's physical and emotional condition, he she will be permitted to work in the health care field **(MUST PROVIDE LABS WITH PHYSICAL EXAMINATION REPORT)**