Friends & Family HOME CARE SERVICES
Tel: (212) 476-0905 / **Fax: (646) 349-4015**
HR@FRIENDSFAMILYHOMECARE.COM

EMPLOYEE PHYSICAL EXAMINATION REPORT

☑ **Pre- Employment Physical Assessment** ☐ **Annual Employment Physical Assessment** ☐ **Return to Work**

Name:	Sex: M F	Marital Status: M S W D
Address	SS:	Title:

PHYSICAL EXAMINATION

HEAD/ENT:	
EYES:	
NECK:	
BREASTS:	
LUNGS:	
CARDIOVASCULAR:	
MUSCULOSKELETAL:	
ABDOMEN:	
GENITOURINARY:	
CENTRAL NERVOUS SYSTEM:	

COMMENTS:

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

LABORATORY TEST RESULTS (Please attach all reports)

TEST	DATE		RESULTS		
RUBELLA TITER			☐ NON-IMMUNE	☐ IMMUNE	LAB VALUE:
MEASLES TITER			☐ NON-IMMUNE	☐ IMMUNE	LAB VALUE:
PPD (ANNUALLY)	1. Date Implanted	1.Date Read:	RESULTS (MM*MM)		
CHEST X-RAY (+PPD)	DATE:		RESULTS		
Flu Vaccine	Date Given:		Expiration:		

IMMUNIZATIONS:	DATE	DATE	DATE
RUBELLA	1.	2.	3.
RUBEOLA/MEASLES	1.	2.	3.
HEPATITIS B VACCINE	1.	2.	3.

DRUG SCREEN **8 Panel COC**	Date:	☐ NEGATIVE (-) ☐ POSITIVE (+)	**(Please Attach Lab Report)**

☐ *This individual is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other substances that may alter his/her behavior.*

☐ *This individual is able to work with the following limitations:*

☐ *This individual in not physically mentally able to work. (specify reason):*

Physician Signature & STAMP:	**Lic. No.**	**Date:**