

## CDPAP ONLY EMPLOYEE PHYSICAL EXAMINATION REPORT

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	'nysical Ass	essme	nt	T-					
Name:				Sex: M F	Mari	tal Status:	M S	W	D
Address				SS:	Tit	le:			
PHYSICAL EXAMINATION									
HEAD/ENT:									
EYES:									
NECK:									
BREASTS:									
LUNGS:									
CARDIOVASCULAR:									
MUSCULOSKELETAL:									
ABDOMEN:									
GENITOURINARY:									
CENTRAL NERVOUS SYSTEM:									
COMMENTS:									
HT: W	/T:	B/	P:	PULSE:	RESP:		TEMP	:	
LABORATORY TEST RESULTS (Please attach all reports)									
TEST		D	ATE		_	ULTS			
RUBELLA TITER				NON-IMMUNE		LAB VALUE:			
MEASLES TITER				☐ NON-IMMUNE		LAB VALUE:			
	1. Date Implanted		1.Date Read:	RESULTS (MM*N	1M)				
PPD									
CHEST X-RAY (+PPD)	DATE:			RESULTS					
Flu Vaccine	Date Given:			Expiration:					
IMMUNIZATIONS:			DATE	DAT	E	_	DATE		
RUBELLA	1.			2.		3.			
RUBEOLA/MEASLES	1.			2.		3.			
HEPATITIS B VACCINE	1.			2.	3.				
			pairment which is of p						
		_	g the habituation or ac	diction to depress	sants, stimular	its, narcotic	s, alcoh	iol oi	other
substances that may	y alter his/her	behavio	or.						
☐ This individual is able to work with the following limitations:									
This individual in no	t physically m	entally a	able to work. (specify reas	son):					
Physician Signature & STAMP:				Lic. No.		Date:			
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