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**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:
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**LABORATORY TEST RESULTS (Please attach all reports)**

TEST	DATE	RESULTS
RUBELLA TITER		<input type="checkbox"/> NON-IMMUNE <input type="checkbox"/> IMMUNE    LAB VALUE:
MEASLES TITER		<input type="checkbox"/> NON-IMMUNE <input type="checkbox"/> 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 is not physically/mentally able to work. (specify reason):*

Physician Signature & STAMP:	Lic. No.	Date:
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