

TRI-MED HOME CARE SERVICES, INC.

EMPLOYEE PHYSICAL EXAMINATION REPORT

PHONE: (347) 727-7200 FAX: (347) 926-4709

Pre-Employment Physical Assessment Annual Assessment Return to work/LOA Other:

Name:	Marital Status: M S W D	Sex: M F
Address:	Social Security#	Title:

PHYSICAL EXAMINATION

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

HT:	WT:	B/P:	PULSE:	RESP:	TEMP:
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LABORATORY TEST RESULTS

TEST	DATE PERFORMED	RESULTS Provide lab values and interpretation		
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):
	2 DATE IMPLANTED	2 DATE READ		RESULTS (mm/mm):
CHEST X-RAY (+PPD)	DATE:	RESULTS:		

IMMUNIZATIONS:	DATE	DATE	DATE
RUBELLA	1.		
RUBEOLA/MEASLES	1.	2.	
HEPATITIS B VACCINE (Optional) Yes _____ No _____	1.		
FLU VACCINE Yes _____ No _____			
DRUG SCREEN (8 PANEL) LAB WORK MUST BE ATTACHED			

This individual is free from any health impairment that is a potential risk to the patient or other employees or which may interfere with the performance of his/her duties including habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol or other substances that may alter behavior.

This individual is able to work with the following limitations:
 This individual is not physically/mentally able to work (specify reason):

Physician's Signature: _____

Lic. # _____ Date: _____

OFFICE STAMP:
