CARE STAFFING
Professionals

PHYSICAL EXAMINATION

Date of Examination: _____ **Discipline**: _____

Name: _____ **Date of Birth**: _____

Gender: M F **Height**: _____ **Weight**: _____ **Blood Pressure**: _____

Visual Acuity: **Left Eye**: _____ **Right Eye**: _____

		NOTES:
ABDOMEN	NORMAL / ABNORMAL	_____
CARDIOVASCULAR	NORMAL / ABNORMAL	_____
CHEST/LUNGS	NORMAL / ABNORMAL	_____
ENDOCRINE SYSTEM	NORMAL / ABNORMAL	_____
GI-GU	NORMAL / ABNORMAL	_____
HEAD/EYES/EARS/NOSE/THROAT	NORMAL / ABNORMAL	_____
HEART	NORMAL / ABNORMAL	_____
LOWER EXTREMITIES	NORMAL / ABNORMAL	_____
LYMPHATIC SYSTEM	NORMAL / ABNORMAL	_____
NEUROLOGICAL	NORMAL / ABNORMAL	_____
SKIN	NORMAL / ABNORMAL	_____
SPINE-MUSCULOSKELETAL	NORMAL / ABNORMAL	_____
UPPER EXTREMITIES	NORMAL / ABNORMAL	_____

Additional Comments: _____

_____

_____

I have performed a physical examination on the above-named individual and have found this person to be in good physical/mental health. The individual is free from any communicable diseases, does not have any medical conditions which might interfere with the health of a client, and is able to function as a healthcare worker without restriction.

Physician's Signature: _____ M.D. #: _____

Physician's Name (please print): _____ Phone #:_____

Address: _____