



## EMPLOYEE PHYSICAL EXAM

Position applied for: \_\_\_\_\_

Date of exam: \_\_\_\_\_

Employee name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Vitals: Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Resps \_\_\_\_\_ B/P \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

SYSTEM	NORMAL	ABNORMAL	If abnormal please explain
Skin			
Eyes			
Ears			
Nose			
Mouth			
Throat			
Respiratory			
Cardiac			
Gastro			
GU			
Neurological			
Musculoskeletal			

By my signature I hereby consent to have the examining physician release any and all information requested by New Beginnings Home Care, Inc.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

To the best of my knowledge I have determined that as of this date, this individual is free from any health impairments which are of potential risks to patients or which might interfere with the performance of their duties, and that there is no evidence that they have habituation or addictions to depressants, stimulants, narcotics, alcohol or any other substance that may alter their behavior

\_\_\_\_\_  
MD Signature

\_\_\_\_\_  
Date

PPD Testing Information:		
Date placed: _____	Site: _____	Signature: _____
Manufacturer: _____	Lot#: _____	Expiration: _____
Date read: _____	Results: _____ induration redness	Signature _____