

# ABSOLUTE HOME HEALTH & HOSPICE

## EMPLOYEE HEALTH EXAMINATION

NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SEX: M F

ADDRESS: \_\_\_\_\_

APPLICANT: HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING?

YES	NO	YES	NO	YES	NO
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___

STATE DETAILS FOR ITEMS CHECKED YES: \_\_\_\_\_

I CERTIFY THAT TO MY KNOWLEDGE I HAVE NO INJURY, ILLNESS OR AILMENT OTHER THAN SPECIFICALLY NOTED AND GIVE THE EXAMINING PHYSICIAN PERMISSION TO SUBMIT A REPORT TO MY EMPLOYER.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

### TO BE COMPLETED BY PHYSICIAN

HEIGHT: \_\_\_\_\_ BLOOD PRESSURE: \_\_\_\_\_ TEMPERATURE: \_\_\_\_\_  
WEIGHT: \_\_\_\_\_ PULSE: \_\_\_\_\_ RESPIRATION: \_\_\_\_\_

### PHYSICAL FINDING:

EENT: \_\_\_\_\_ ABDOMEN \_\_\_\_\_  
HEART: \_\_\_\_\_ EXTREMITIES: \_\_\_\_\_  
LUNG: \_\_\_\_\_

GENERAL OBSERVATIONS: \_\_\_\_\_

PPD DATE: \_\_\_\_\_ CHECKED: \_\_\_\_\_ / \_\_\_\_\_ MM RUBELLA TITER: \_\_\_\_\_

HEPATITIS SCREENING: \_\_\_\_\_ VARICELLA ANTIBODIES: \_\_\_\_\_

I HAVE FOUND NO INDICATION OF ANY CONDITION WHICH MIGHT REPRESENT A POSSIBLE HAZARD TO THE HEALTH OF PARTICIPANT(S) OR OTHER EMPLOYER(S)

DATE: \_\_\_\_\_ EXAMINER'S SIGNATURE: \_\_\_\_\_ PHONE: \_\_\_\_\_

EXAMINER'S NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_