THE ROADS
Home Health Care
YOUR ROAD TO RECOVERY

PHYSICAL EXAMINATION FORM

EMPLOYEE NAME _____ JOB TITLE _____

PHYSICIAN NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

PHONE NO. _____

THE PHYSICAL EXAMINATION PERFORMED BY THE ABOVE REFERENCED PHYSICIAN CERTIFIES THE FOLLOWING:

THE EMPLOYEE REFERENCED ABOVE WAS GIVEN A PHYSICAL EXAMINATION ON THE DATE STATED BELOW AND IS IN GOOD PHYSICAL CONDITION. THE EMPLOYEE SHOWS NO EVIDENCE OF COMMUNICABLE DISEASES AND HAS NO PHYSICAL LIMITATIONS IN PERFORMING HIS/HER JOB DUTIES.

_____ _____

Physical Examination Date **Physician Signature**

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In addtion to physical examination, the staff is require to complete one of the following:

DATE OF PPD TEST _____ **Date of blood test QuantiFERON** _____

PPD RESULTS _____ **Result of QuantiFERON** _____

_____ _____

Physician Signature **Date**

ADDITIONAL COMMENTS: _____

_____

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I CERTIFY THAT I AM FREE OF ANY LOWER BACK AILMENTS OR OTHER AILMENTS WHICH COULD PREVENT ME FROM PERFORMING MY JOB DUTIES IN A SATISFACTORY MANNER.

_____ _____

Employee Signature **Date**

REVISED 02/2022