PRE-EMPLOYMENT PHYSICAL EXAM AND STATEMENT OF HEALTH

EMPLOYEE NAME: ____

EMPLOYEE DATE OF BIRTH (MM/DD/YYYY): ____

PHYSICIAN NAME OR PRACTICE, ADDRESS AND PHONE NUMBER (MUST BE STAMPED):

____

____

____

PHYSICAL EXAMINIATION DATE (MM/DD/YYYY): ______________________________________

(EMPLOYEE NAME HERE): ____ ***,*** Is in overall good health and has no work restrictions. You have found him/her to be fit for work and free of communicable diseases (which could be a potential risk to patient's being cared for by this individual and may interfere with the duties performed by this employee as a healthcare worker).

PROVIDER'S NAME (PLEASE PRINT): ____

PROVIDER'S SIGNATURE: ____

TODAY'S DATE (MM/DD/YYYY): ____

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