Good Care Agency, Inc.

☐ Pre-Employment Physical Assessment ☐ Annual Assessment ☐ Return to work/LOA ☐ Other:

Name:	SS#:	Sex: M ☐ F
Address:		Title:

PHYSICAL EXAMINATION

HEAD/ENT:					
EYES:					
NECK:					
BREAST:					
LUNGS:					
CARDIOVASCULAR:					
MUSCULOSKELETAL:					
ABDOMEN:					
GENITOURINARY:					
CENTRAL NERVOUS SYSTEM:					
COMMENTS:					
HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

LABORATORY TEST RESULTS

TEST	DATE PERFORMED	RESULTS	
RUBELLA TITER (*Attach Lab Report)		Non-Immune Immune **LAB VALUE:**	
MEASLES TITER(*Attach Lab Report)		Non-Immune Immune **LAB VALUE:**	
PPD(ANNUALLY) 1st Step (*2 Step PPD required)	1.Date implanted:	1.Date read:	Results(mmxmm):
	Lot #:	Exp.date:	☐ Neg(-)☐ Pos(+)
PPD(ANNUALLY) 2nd Step (*2 Step PPD required)	1.Date implanted:	1.Date read:	Results(mmxmm):
	Lot #:	Exp.date:	☐ Neg(-)☐ Pos(+)
CHEST X-RAY (if+PPD) *Report	Date:	Results:	
URINE DRUG SCREEN (*Attach Lab Report)	Date:	Results:	

IMMUNIZATIONS:	DATE	DATE	DATE
RUBELLA (*Attach Lab Report)	1.		
RUBEOLA/MEASLES (*Attach Lab Report)	1.	2.	
HEPATITIS B VACCINE	1.	2.	3.
INFLUENZA:	1.	2.	3.

This individual is free from any health impairment that is a potential risk to the patient or other employee or which may interfere with the performance of his/her duties including the habituation or addiction to drugs or alcohol.

This individual is able to work with the following limitations:

This individual is not physically/mentally able to work (specify reason):

Office Stamp

PHYSICIAN SIGNATURE: LIC.NO. DATE:

***Copies of the lab reports must be attached to the physical form**