PRE-EMPLOYMENT PHYSICAL EXAMINATION

Name _____ Date: _____

D.O.B:_____ Classification:_____

PPD

1st Step: Date Placed _____ Date Read _____ Results:_____

2nd step (if required): Date Placed _____ Date Read _____ Results:_____

Physician's Signature_____

If result is positive please attach the Chest X- Ray Report
Titre / Immunization Records
Please specify immunity status as well as the source used to verify this status.
Immunization records and or Titre results must be attached.

Measles (Rubeola) Vaccine/Titre: _____

Mumps Vaccine/Titre: _____

Rubella Vaccine/Titre: _____

Varicella Vaccine/Titre: _____

*Rubeola Immunity must be verified if patient DOB is after 11/1/57

Hepatitis B Vaccination Dates

1. _____ 2. _____ 3. _____

Statement of Health

The above named is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation of addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

Vital Signs: Pulse:_____ Blood Pressure:_____

Date: _____Physician Name: _____
Please Print

Address: _____ Phone: _____

Physician's Signature_____

THIS FORM MUST BE COMPLETED AND RETURNED WITH REQUIRED ATTACHMENTS PRIOR TO ACTIVE EMPLOYMENT!

Please Fax Or Email This to Prominent Medical Staffing (See below)

Fax to 717-918-6108 or email to dgipe@prominentstaffing.com