

# MAGIC HOME CARE LLC

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## PRE-EMPLOYMENT PHYSICAL EXAMINATION FORM – CDPAP

Name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB:
Address:	SS#:	Title:

### PHYSICAL EXAMINATION

HEAD/ENT:
EYES:
NECK:
BREASTS:
LUNGS:
CARDIOVASCULAR:
MUSCULARSKELETAL:
ABDOMEN:
GENITOURINARY:
CENTRAL NERVOUS SYSTEM:

Comments:

Height:	Weight:	BP:	Pulse:	Resp:	Temp:
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### IMMUNIZATIONS AND LABORATORY TEST RESULTS (Please attach all laboratory reports)

Immunization or Serologic Titer:	Date Performed	Results
Rubella <i>1 dose MMR or titer proving immunity</i>		<b>Attach immunization record (preferred)</b> OR <input type="checkbox"/> Immune / <input type="checkbox"/> Not Immune; Lab value: _____
Rubeola/Measles <i>2 doses MMR or titer proving immunity</i>		<b>Attach immunization records (preferred)</b> OR <input type="checkbox"/> Immune / <input type="checkbox"/> Not Immune; Lab value: _____

### *Only one of IGRA or TST testing should be completed*

IGRA blood test (QuantiFERON, T-SPOT)			<b>Attach lab report</b>
TST skin test, step 1 (PPD)	Date Implanted:	Date Read:	Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive Induration: _____ mm
TST skin test, step 2 (PPD) <i>Administer 1-3 weeks after step 1</i>	Date Implanted:	Date Read:	Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive Induration: _____ mm

Chest X-ray (if IGRA or TST is positive) **Attach lab report**

This individual 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 or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

This individual is able to work with the following limitations: \_\_\_\_\_

This individual is NOT physically/mentally able to work (*specify reason*): \_\_\_\_\_

Physician signature:	License No.:	Date:
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\*\*\*\*\*PLEASE STAMP AND ATTACH ALL LAB REPORTS!\*\*\*\*\*