MAGIC HOME CARE LLC

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PRE-EMPLOYMENT PHYSICAL EXAMINATION FORM

Name:	Sex: ☐ Male ☐ 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:

IMMUNIZATIONS AND LABORATORY TEST RESULTS (Please attach all laboratory reports)

Immunization or Serologic Titer:	Date Performed	Results
Rubella *1 dose MMR or titer proving immunity*		**Attach immunization record (preferred)** **OR** ☐ Immune / ☐ Not Immune; Lab value: _____
Rubeola/Measles *2 doses MMR or titer proving immunity*		**Attach immunization records (preferred)** **OR** ☐ Immune / ☐ Not Immune; Lab value: _____
Urine Drug Screen (8-panel)		**Attach lab report**

Only one of IGRA or TST testing should be completed

IGRA blood test (QuantiFERON, T-SPOT)			**Attach lab report**
TST skin test, step 1 (PPD)	Date Implanted:	Date Read:	Results: ☐ Negative ☐ Positive Induration: _____ mm
TST skin test, step 2 (PPD) *Administer 1-3 weeks after step 1*	Date Implanted:	Date Read:	Results: ☐ Negative ☐ 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:

****PLEASE STAMP AND ATTACH ALL LAB REPORTS!****