WELLCARE HEALTH MANAGEMENT INC.

EMPLOYEE PHYSICAL EXAMINATION REPORT

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

Name:	Marital Status: M S W D	Sex: M F
Address	SS #:	Title:

PHYSICAL EXAMINATION

HEIGHT:	PULSE:
WEIGHT:	RESP:
BLOODPRESSURE:	TEMPERATURE:
HEAD/ENT:	CARDIOVASCULAR:
EYES:	MUSCULOSKELETAL:
NECK:	ABDOMEN:
BREASTS:	GENITOURINARY:
LUNGS	CENTRAL NERVOUS SYSTEM:

COMMENTS:

LABORATORY TEST RESULTS

1st PPD/MANTOUX **(2nd Step Required if Result Is Negative)**	1.DATE IMPLANTED:	2.DATE READ:	RESULTS **(mmXmm):**_____ ☐ NEGATIVE(-) ☐ POSITIVE(+)
	LOT#:		
PPD/MANTOUX 2nd Step **(If 1st Step PPD is NEGATIVE)**	1.DATE IMPLANTED:	2.DATE READ:	RESULTS **(mmXmm):**_____ ☐ NEGATIVE(-) ☐ POSITIVE(+)
	LOT#:		
CHEST X-RAY **(If 1st Step PPD is POSITIVE)**	**DATE:**	**RESULTS**: ☐ NEGATIVE(-) ☐ POSITIVE(+) **(PLEASE ATTACH LAB REPORTS)**	
DRUG SCREEN (ANNUALLY) **(*ATTACH LAB REPORT)**	**DATE:**	**RESULTS:** ☐ NEGATIVE(-) ☐ POSITIVE(+) **(PLEASE ATTACH LAB REPORTS)**	

IMMUNIZATIONS

RUBELLA TITTER **(*ATTACH Lab Report)** If not immune, please provide MMR Vaccine	**LAB VALUE:**	☐ NON-IMMUNE	☐ IMMUNE
	1.		
RUBEOLA/MEASLES TITTER **(*ATTACH Lab Report)** (only if born on or after 1/1/1957) If not immune, please provide MMR Vaccine	**LAB VALUE**:	☐ NON-IMMUNE	☐ IMMUNE
	1.	**2.**	
HEPATITIS B VACCINE	**1.**	**2.**	**3.**
INFLUENZA VACCINE **(ANNUALLY MANDATORY)**	**Date Received:**	**Type of Vaccine:**	
	Dose:	**Name of Administrator:**	
H1N1 VACCINE **(Mandatory when available)**	**Date Received:**	**Type of Vaccine:**	
	Dose:	**Name of Administrator:**	

☐ **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):**

(Doctor's Stamp Here)

Physician Signature:	**Lic. #:**	**Date:**
Xincon RN Signature:		**Date:**