XINCON HOME HEALTH CARE SERVICES 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: LOT#:	2.DATE READ:	RESULTS (mmXmm):_____ ☐ NEGATIVE(-) ☐ POSITIVE(+)
PPD/MANTOUX 2nd Step (If 1st Step PPD is NEGATIVE)	1.DATE IMPLANTED: LOT#:	2.DATE READ:	RESULTS (mmXmm):_____ ☐ NEGATIVE(-) ☐ POSITIVE(+)
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: Dose:	Type of Vaccine: Name of Administrator:
H1N1 VACCINE (Mandatory when available)	Date Received: Dose:	Type of Vaccine: 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: