

Rockaway CDPAP Physical Examination

<input type="checkbox"/> Pre-Employment Physical		<input type="checkbox"/> Return to Work / LOA		<input type="checkbox"/> Annual	
Name:		Marital Status:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:		SS#:		DOB:	

Physical Examination					
Head/ENT:					
Eyes:					
Neck:					
Breasts:					
Lungs:					
Cardiovascular:					
Musculoskeletal:					
Abdomen:					
Genitourinary:					
Central Nervous System:					
Comments:					
HT:	WT:	B/P:	Pulse:	Resp:	Temp:

Please Send Copy of Laboratory Results			
Test	Date Performed	Results – Provide Lab Values and Interpretation	
Rubella Titer			
Measles Titer			
PPD (Annually)	1. Date Implanted 2. Date Implanted	1. Date Read 2. Date Read	1. Results (mmxmm) 2. Results (mmxmm)
QuantiFeron (TB-Gold)			
Chest X-Ray (+PPD)			
Immunizations		Date	
Rubella		1.	
Rubella / Measles		1.	2.
Hepatitis B Vaccine		1.	2. 3.
Other		1.	2. 3.

<input type="checkbox"/> 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.
<input type="checkbox"/> This individual is able to work with the following limitations:
<input type="checkbox"/> This individual is not physically/mentally able to work (specify reason):

Physician Stamp:	Physicians Signature:		
	Lic #:		
	Phone #:	Date:	