New Lanark Healthcare Services, INC

Physician Examination Report

TO BE COMPLETED BY EMPLOYEES PHYSICIAN:

Employee Name: _____ DATE: _____

Job Title: _____

The above named person has been offered employment, or is currently employed by New Lanark Healthcare Inc. Agency. It is our company policy, in accordance with Federal and State regulations to require a physical examination for all of our health care workers. We would appreciate your completing the following information. Thank you.

I hereby authorize the release of Information below to New Lanark Healthcare Services_____* (Employee Signature)

Height_____Sex_____Temp_____Resp_____

Weight_____Age_____Pulse_____B\P_____

Allergies_____

Demonstrates adequate pain-free range of motion of neck, shoulders, wrists, hands. spine, hips, knees, ankles: ___Yes ___No

Comments:

_____

PLEASE INDICATE DATES AND FINDINGS OF THE FOLLOWING:

Measles/ Mumps/ Rubella: MMR Vaccine Given: _____ Date_____

(If vaccine not given, complete the following:)

Rubella Titre: Date: _____Result: _____ **Rubella Vaccine:** Date: _____Result: _____

Rubeola Titre: Date: _____ Result: _____ **Rubeola Vaccine:** Date: _____ Result: _____

(Born after **1956)**

***Varicella* Titre: Date:**_____ Result: _____

#1 PPD: Date Administered: _____Date **Read:** _____**Result: 0 mm**_____ **1-4 mm** _____*5-9* **mm** _____

(If #1 PPD Negative, must have #2 PPD within 1-3 weeks 10-15 mm*_____ Over 15 mm*_____

According to CDC Guidelines)

#2 PPD: Date Administered: _____**Date Read:**_____ **Result 0 mm**_____ 1-4 **mm**_____ *5-9* **mm** _____

10-15mm*_____ Over 15 mm*_____

***If positive PPD must have Chest X-Ray:** Date: _____ **Result** _____

DRUG SCREEN: Date_____ **Negative**_____ **Positive** _____

HEPATITIS B:

 # 1 Vacc. Date _____ **#2 Vacc. Date** _____ **#3 Vacc. Date**_____ Results _____

HEPATITIS B: Declined _____ **Contraindicated**_____

Are there any physical, psychological or mental limitations which would impair the performance of this employee?

***YES*____ NO___ If yes please explain:**

_____

_____

_____

This applicant was interviewed and examined by me. I found his/her health status adequate for work in the health care field.

_____

Physician Signature Date Address Phone #