Employee Physical Examination Form

First Name:_____ **Last Name:**_____ **Date of birth:** _____

TO BE COMPLETED BY A PHYSICIAN, NP OR PA: (MUST BE PERFORMED BY A PHYSICIAN, NP or PA)

Date of Examination:_____ General Appearance:_____

Height:_____Weight:_____Allergies: _____

Temperature: _____ Pulse: _____ Respiration: _____ B/P:_____

	NORMAL	ABNORMAL	If abnormal, Comments:
SYSTEM			
Skin			
Eyes			
Ears			
Nose			
Throat/Dental			
Cardiovascular			
Respiratory			
Gastro Intestinal			
Genito-Urinary			
Neurological			
Musculoskeletal			
Other			

Summary of Findings:

_____

_____

_____

I hereby certify that I have examined the above applicant and the above is a complete and accurate assessment of my examination. I hereby state that this employee is in good physical and mental health which is required to perform the essential functions of the position for which he or she is applying.

Physician, NP or PA Signature:_____Today's Date: _____

Address:_____Phone:_____