ALWAYS HOME CARE

3131 Coney Island Ave., Brooklyn NY 11235 Phone: 718.843.8430 1 Fax: 718.646.0680

☐ 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

HEAD/ENT:________________________________

EYES:________________________________

NECK:________________________________

BREASTS:________________________________

LUNGS:________________________________

CARDIOVASCULAR:________________________________

MUSCULOSKELETAL:________________________________

ABDOMEN:________________________________

GENITOURINARY:________________________________

CENTRAL NERVOUS SYSTEM:________________________________

COMMENTS:________________________________

Height : __________ Weight:____________ B/P:__________ Pulse:__________ Resps:__________ Temp:__________

LABORATORYTEST RESULTS (all lab results must be attached)			
TEST	DATE	RESULTS	
RUBELLA TITER		o NON-IMMUNE o IMMUNE I LAB VALUE	
MEASLES TITER		o NON-IMMUNE o IMMUNE I LAB VALUE:	
PPD (ANNUALLY)	Date implanted:	Date read:	Result.
QUANTIFIRON	Date implanted'	Date read:	Result:
CHEST X-RAY (+PPD OR TB GOLD)			
DRUG SCREEN			
IMMUNIZATION	DATE	DATE	DATE
RUBELLA	1.		
RUBEOLA/MEASLES	1.	2-	
HEPATITES B VACCINE	1.	2.	3.
INFLUENZA VACCINE	1.		
COVID 19 VACCINE	1	2	EXEMPT o DOC __Y___N

☐ 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): 1

Please place your stamp here

Physician Signature: Lic. No: Date: