PRE-PLACEMENT PHYSICAL EXAMINATION

(To be completed by Physician)

NAME: (PLEASE PRINT)			
GENERAL APPEARANCE	PERSONAL HYGIENE	WEIGHT	некнт
PULSE RATE	BLOOD PRESSURE	SKIN	
EYES: VISION: (WITHOUT GLASSES) LEFT RIGHT CONTACT LENSES (WITH GLASSES) LEFT RIGHT COLOR VISION			
EARS: HEARING:			
NOSE	THROAT	MOUTH	
TEETH	NECK	THORAX	
BREASTS	HEART	LUNGS	
ABDOMEN			
HERNIA LEFT RIGHT			
RECTUM	PILONIDAL DISEASE	UPPER EXTREMITIES	
HANDS	LOWER EXTREMITIES	FEET	
BACK	NEUROLOGIC ABNORMALITY	EMOTIONAL DISORDER	
LABORATORY TESTS REQUIRED: BLOOD SEROLOGY TEST: DATE (Needed for those applying for Cafeteria Position Only) URINALYSIS HEMOGLOBIN LUMBAR SPINE X-RAY (IF INDICATED)			
IMMUNIZATIONS RECOMMENDED: (MAY BE COMPLETED AFTER STARTING WORK) TETANUS (WITHIN 8 YRS.) - DATE			
TUBERCULIN HISTORY - RESULT OF MOST RECENT T.B. TINE TEST OR CHEST X-RAY, IF KNOWN: NEG. POS. YEAR			
PHYSICIAN'S DIAGNOSIS:			
PHYSICIAN'S RECOMMENDATIONS TO THE PROSPECTIVE EMPLOYER: MEDICALLY ACCEPTABLE FOR ANY TYPE OF WORK LIMITATIONS OR RESTRICTIONS ADVISABLE, AS FOLLOWS: GROUND LEVEL WORK ONLY AVOID SKIN IRRITANTS AVOID EXCESSIVE STOOPING, BENDING, AND CROUCHING NO HAZARDOUS MACHINERY AVOID DUST AND FUMES AVOID EXCESSIVE STANDING OR WALKING NO COMPANY VEHICLES LIMIT LIFTING TOLBS. LOW NOISE LEVEL VISUAL RESTRICTIONS: (Please Specify:			
WERE FINDINGS AND RECOMMENDATIONS DISCUSSED WITH PATIENT?			
DATE:		NAME OF PHYSICIAN: (Type or Print)	
ADDRESS: (Street, City, State, Zip)	(PHONE)	SIGNATURE OF M.D.:	
EMPLOYERS NOTE: INFORMATION ACQUIRED FROM THIS FORM SHOULD BE USED IN YOUR DECISION TO PLACE AN INDIVIDUAL IN A POSITION ONLY WHEN A PHYSICAL OR MENTAL DISABILITY CAN BE SHOWN TO PREVENT THE INDIVIDUAL FROM ADEQUATELY PERFORMING ON THE JOB.			