Crown Top
Nurse Staffing, LLC

PHYSICAL EXAMINATION FORM

NAME: _____ SEX: ☐ MALE ☐ FEMALE BIRTHDATE: ____/____/_____
MAILING ADDRESS: _____ CITY: _____
STATE: _____ ZIP: _____ PHONE: (_____)_____ ☐ HOME ☐ CELL
HAVE YOU HAD A SERIOUS ILLNESS, INJURY, OR MAJOR SURGERY? IF SO, DESCRIBE: _____
_____

TO BE COMPLETED BY EXAMINING PHYSICAN/PROVIDER

1. CURRENT COMPLAINTS/DISABILITIES PERTINENT TO PATIENTS ABILITY TO PERFORM JOB DUTIES: _____
   _____
2. MEDICATIONS USED: PRESCRIPTION AND OVER-THE-COUNTER:

MED NAME	INDICATION	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. SIGNIFICANT MEDICAL HISTORY: ACCIDENTS, DEFORMITIES, SURGERIES, BACK PROBLEMS, COMMUNICABLE DISEASES, ETC.: _____
   _____
4. EXAMINATION COMMENTS AND FINDINGS: _____
   _____

REQUIRED TUBERCULOSIS SCREENING

TESTS MUST HAVE BEEN COMPLETED WITHIN THE LAST 12 MONTHS

DATE GIVEN: ___/___/_____ DATE READ: ___/___/_____ RESULTS: ☐ NEGATIVE ☐ POSITIVE
CHEST X-RAY (IF PPD WAS POSITIVE) DATE____/____/_____ RESULTS: ☐ NEGATIVE ☐ POSITIVE

THE ABOVE NAMED HAS NO COMMUNICABLE OR DISABLING DISEASE, NOR HEALTH CONDITION THAT WOULD CREATE A HAZARD TO THEMSELVES, VISITORS, COWORKERS OR PATIENTS AT THIS TIME. IT HAS BEEN DETERMINED THEY ARE ABLE TO PERFORM THE PHYSICAL ACTIVITIES REQUIRED.

EXAMINER NAME AND SIGNATURE: _____ DATE___/___/___
ADDRESS: _____ PHONE: (____) _____

I GIVE PERMISSION TO RELEASE A COPY OF THIS FORM TO AFFILIATING CLINICAL FACILITIES
EMPLOYEE SIGNATURE: _____ DATE___/___/___

PLEASE ATTACH PPD AND CHEST X-RAY RESULT FORMS