TPF Nursing

PRE-EMPLOYMENT PHYSICAL EXAM

TO BE COMPLETED BY A LICENSED MD,DO, NP,PA,CNM

Applicant _____**Address** _____**DOB**_____

TO PHYSICIAN: A health examination is required for the above named person. Please enter details of all requested information. LABORATORY REPORTS MUST BE ATTACHED. Incomplete or illegible information may be rejected

- *Does applicant have any personal health considerations that may impact his/her ability to satisfactorily perform the duties given on a particular assignment (including but not limited to habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs which could alter his/her behavior?* NO____YES_____ If yes, please describe:_____
- ***Is Applicant in good health without restrictions or limitations?*** NO _____ YES _____

MEDICAL HISTORY:

- Any major illness or health impairment _____
- Hospitalization / Serious injury _____
- Any significant finding in patient's past history? _____
- Any significant finding in patient's family's health history_____
- Allergy_____ Latex/non-medication allergies: NO___ YES___ If yes, please specify:_____
- Medication Currently being taken: _____

PHYSICAL EXAMINATION (notate all spaces, draw-through lines are not acceptable):

Height: _____ Weight: _____ BP: _____ Pulse: _____ Respiration: _____ Temp: _____

Examined:	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
General Appearance	_____	_____	HEENT	_____	_____	Breasts	_____	_____	Abdomen	_____	_____
Neurological Exam	_____	_____	Heart	_____	_____	Lymph Nodes	_____	_____	GU Exam	_____	_____
Musculoskeletal	_____	_____	Lungs	_____	_____	Pelvic Exam	_____	_____	Rectal Exam	_____	_____
Extremities	_____	_____	Neck	_____	_____	COMMENTS:	_____				

Immunizations: **(Please include *lab report with values)***

- **Two (2) PPD Tests (Mantoux) or one (1) Interferon Gamma Release Assay (e.g. Quantiferon) required:**

PPD Test 1: (w/in 12 months)
Date placed:_____ Date read: _____
Results: _____ mm ☐ NEG ☐ POS

PPD Test 2: (w/in 3 months)
Date placed:_____ Date read: _____
Results: _____ mm ☐ NEG ☐ POS

Quantiferon (of other IGRA):
Date: _____
Result:_____

If PPD positive, earliest date of + PPD?_____ History of BCG?Y___N___ Date _____ Was Tb prophylaxis taken?N___Y___
What medication? _____ How long? _____ In your opinion what caused + PPD? _____

- **Chest X-Ray** (for + PPD or positive IGRA) Date: _____ Result:_____ ***(Chest X-ray must be attached)***
- **Rubella** antibody titer: _____ Date: _____ (***Attach Lab report)*** OR vaccine date: _____
- **Rubeola** antibody titer: _____ Date: _____ (***Attach Lab report)*** OR 2 doses of live vaccine dates:(1) _____ (2) _____ Exempt if DOB before 1957
- **Mumps** antibody titer: _____ Date: _____ (***Attach Lab report)*** OR 2 doses of live vaccine dates: (1) _____ (2) _____
- **Varicella** antibody titer: (required in all cases) _____ Date: _____ (***Attach Lab report)*** Vaccination dates: (1) _____ (2) _____
- **Hepatitis B** surface antibody titer: _____ (***Attach Lab report)*** Vaccine dates:(1)_____(2)_____(3)_____(or Declination)
- **Tdap vaccine** (within 10 years) Date: _____ Lot #: _____
- **Flu Vaccine** Date: _____ Lot#: _____ Mfr: _____ Expiration: _____

_____ _____

Physician Signature Date

License number: _____
Physician Name printed or stamp: _____ State: _____
Telephone: _____ Address: _____