BLESSED HANDS HOME CARE AGENCY, LLC. 

3221 S. MICHIGAN ST. SOUTH BEND, IN. 46614

PH: (574)-383-0403 Fax: (574)-231-4514

PHYSICAL/MEDICAL FORM

EMPLOYEE NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL CLEARANCE:**

A. Tuberculin PPD –Date Test Administered \_\_\_\_\_\_\_\_\_\_\_

Date Test Read: \_\_\_\_\_\_\_\_ Size: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lot # \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Or Chest X-Ray \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICAL EXAMINATION:**

WT \_\_\_\_\_\_ lbs. HT\_\_\_\_\_\_\_\_ inches Blood Pressure\_\_\_\_\_\_\_\_\_\_ Pulse\_\_\_\_\_\_\_\_ Temp\_\_\_\_\_\_

**SYSTEM NORMAL ABNORMAL SYSTEM NORMAL ABNORMAL**

EENT [ ] [ ] Respiratory [ ] [ ]

Cardiovascular [ ] [ ] Gastrointestinal [ ] [ ]

Genitourinary [ ] [ ] Endocrine [ ] [ ]

Neurological [ ] [ ] Musculoskeletal [ ] [ ]

Dermatological [ ] [ ] Physical Abilities [ ] [ ]

**MEDICAL STATEMENT**

After examining this patient I have determined that he/she is free from malignant, communicable or

mental diseases and from any illness, defect or deformity, which would impair or prevent the

performance of duties, and functions or responsibility.

Physician Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Examining Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_