



PHYSICAL FORM

Employee: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____

Physical Examination:

I have examined the above patient and found him/her to be in satisfactory condition to work; he/she is free from signs & symptoms of communicable disease including TB and does not have any condition which would interfere with the performance of their duties, including the transfer of patients, and the provision of personal care services

Physician Signature

Date

I hereby authorize and release this information pertaining to my medical records to my employer, All Stat Home Health, Inc.

Employee Signature

Date