



**PREEMPLOYMENT PHYSICAL EXAMINATION**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Are you allergic to natural rubber latex? YES/NO

**Titers**

Varicella: Date \_\_\_\_\_ Results \_\_\_\_\_  
Mumps: Date \_\_\_\_\_ Results \_\_\_\_\_  
Rubella: Date \_\_\_\_\_ Results \_\_\_\_\_  
Rubeola: Date \_\_\_\_\_ Results \_\_\_\_\_  
Hepatitis B: Date \_\_\_\_\_ Results \_\_\_\_\_

Copies of lab results must be submitted!

**Immunizations**

Varicella #1: Date \_\_\_\_\_  
Varicella #2: Date \_\_\_\_\_  
Mumps #1: Date \_\_\_\_\_  
Mumps #2: Date \_\_\_\_\_  
Rubella #1: Date \_\_\_\_\_  
Rubella #2: Date \_\_\_\_\_  
Rubeola #1: Date \_\_\_\_\_  
Rubeola #2: Date \_\_\_\_\_  
Hepatitis B Vaccine #1: Date \_\_\_\_\_  
Hepatitis B Vaccine #2: Date \_\_\_\_\_  
Hepatitis B Vaccine #3: Date \_\_\_\_\_

**TB Screening**

TB Skin Test: Date placed \_\_\_\_\_ Time \_\_\_\_\_ Date read \_\_\_\_\_ Time \_\_\_\_\_ Results \_\_\_\_\_ MM  
QuantIFERON TB Gold Test: Date drawn: \_\_\_\_\_ Results \_\_\_\_\_  
Chest x-ray: Date given \_\_\_\_\_ Results \_\_\_\_\_  
TB Fit Test: Mask Size \_\_\_\_\_  
General Comments:

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

The above-named individual has been examined by me and is free from symptoms indicating the presence of an infectious disease and does not have any condition, which would interfere with the performance of his/her duties as a health care professional.

\_\_\_\_\_  
Primary Care Provider's Name Primary Care Provider's Signature Date

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Physician ID #: \_\_\_\_\_