Registry Network
Incorporated

ANNUAL PHYSICAL EXAMINATION

Name: _____

Date: _____

Are you allergic to natural rubber latex? ☐YES or ☐NO

TB Screening

TB Skin Test: Date placed _____Time _____ Date read _____ Time_____ Results ___ MM
Or
QuantiFERON TB Gold Test: Date drawn: _____ Results _____
Lab results must be submitted. Handwritten only results are not accepted.
Or
Chest x-ray if TB skin test is Positive: Date given _____ Results _____
Report must be submitted. Handwritten only results are not accepted.
And
N95 TB Fit Test: Mask Size _____ and Type _____

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 #: _____

Form Updated 9-3-26