

IF SIGNIFICANT REACTION WAS REPORTED, THE PHYSICIAN REPORT MUST STATE THAT THE APPLICANT IS FREE FROM CURRENT TUBERCULOSIS DISEASE OR IS UNDER ADEQUATE CHEMOTHERAPY FOR TUBERCULOSIS DISEASE.

	Yes	No	If Yes, Explain
Allergies	☐	☐	
Asthma.....	☐	☐	
Cardiac.....	☐	☐	
Chemical Dependency.....	☐	☐	
Drugs	☐	☐	
Alcohol.....	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder.....	☐	☐	
Hypertension.....	☐	☐	
Neuromuscular Disorder.....	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder.....	☐	☐	
Other (Specify).....	☐	☐	

	Normal	Abnormal	Not Examined	Comments
• Height (inches)				
• Weight (pounds)				
• Pulse				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes –Visual Acuity R / L /				
• Eyes – Color Vision				
• Ears – Hearing dB R L				
• Nose and Throat				
• Teeth and Gingiva				
• Lymph Glands				
• Heart – Murmur, etc.				
• Lung – Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her work role? If so, specify

Physician Address

The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. I understand that any false or misleading statements may cause termination of my employment.

I authorize the physician or other person to disclose any knowledge or information pertaining to my health to the employing authority for whom this examination is performed.

Signature of Employee

Date