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HomeCentris HEALTHCARE
HOME-CENTRIC HEALTHCARE STRATEGIES

# PHYSICAL EXAMINATION FORM

*(Needs to be completed prior to assignment)*

Applicant's Name: _____

**Dear Physician,**

The above-named applicant is applying to be a clinician with our company. This job requires assistance with activities of daily living, such as bathing, dressing, toileting, assisting with transferring and ambulating, and limited household chores. As provider, he/she will be caring for individual(s) with various disabilities and illnesses and it might be necessary that he/she lifts or turns the individual in bed. The provider must be physically capable of providing personal care and have a positive attitude toward the sick and disabled. The provider must also be able to read and write and have the ability to understand and carry out the plan of care as instructed by the registered nurse. After you have examined the applicant, please complete and sign this form and return it to him/her.

General: Date of birth _____ Temperature _____ Pulse _____ Respiration _____
Blood Pressure _____ Weight _____

**Please put *WNL* (within normal limits) if findings are normal or describe any abnormalities.**

| | | | |
|---|---|---|---|
| Skin | _____ | Lungs | _____ |
| Head and Neck | _____ | Blood Vessels | _____ |
| Ears/Nose/Throat | _____ | Abdomen | _____ |
| Eyes | _____ | Extremities | _____ |
| Neurological | _____ | Heart | _____ |
| Lymph Nodes | _____ | Speech | _____ |
| Chest/Breast | _____ | Mental Health | _____ |

Is patient free of communicable diseases? □ Yes □ No
If "No" please describe:
**TB test:** (Please circle one): Chest X-Ray TST Date: _____

Result: _____

**Hepatitis B test**: □ Yes □ No Result: _____ Date: _____

**Hepatitis B vaccination**: □ Yes □ No Date: _____ Vaccination Declined: □

Electrocardiogram (if indicated) _____

Current medical problems:

I have examined the above-named candidate and determined that he/she __ IS __ IS NOT capable of performing personal care services.

Physician's Signature: _____

Physician's Name: _____ Date: _____

Address and Phone: _____

For TB and Hep B test results: please submit original x-ray report, lab report, or physician's statement on office stationary. Alternatively, please affix a signature stamp.