

MATCH ONE STAFFING

205-07 Hillside Avenue
 Suite# 26
 Hollis, N.Y. 11423
 Phone:[718] 217-1666
 Fax# [718] 217-1667

Physical Examination Report

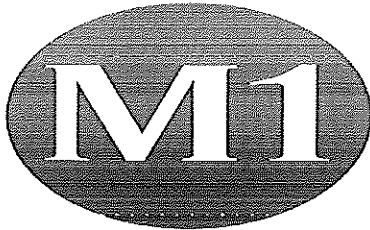
NAME:		DATE OF PHYSICAL:
ADDRESS:		SOCIAL SECURITY:
HEIGHT:	WEIGHT:	DATE OF BIRTH:

LABORATORY RESULTS

Tuberculin Test-PPD	Date Administered _____	Date Read _____	Result _____
2nd Step (If positive)	Date Administered _____	Date Read _____	Result _____
Quantiferon Gold	Date Administered _____	Date Read _____	Result _____
Chest X-Ray	Date _____	Results _____	
Mumps, Measles, Rubella	Immunization date: _____	Titer Results: <u>Must be in a lab printout</u>	
Varicella Zoster	Immunization date: _____	Titer Results: <u>Must be in a lab printout</u>	
Tetanus & Diphtheria	Date: _____		
Hepatitis Results: (HepBAb/HepBAAb / HepCAb)	Vaccine#1 _____	Vaccine#2 _____	Vaccine#3 _____
Flu Vaccine	Immunization date: _____	Location : _____	Lot#: _____

Lab Results for MMR/Varicella/ Hepatitis Titers must be attached, as well as results form a Drug Screening.

EVALUATION OF SYSTEMS:	Findings:		Comments / Description
Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Nose	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Mouth/Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Head/Face/Neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Breasts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Lungs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cardiovascular	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Extremities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Abdomen	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Gastrointestinal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Endocrine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Musculoskeletal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Integumentary	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Renal/Urinary	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Reproductive	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Lymphatic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Nervous System	<input type="checkbox"/> Yes	<input type="checkbox"/> No	



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Tuberculosis Screen Form

NAME _____

DATE OF PHYSICAL _____

LAST PPD (DATE AND RESULTS) _____

LAST X-RAY (DATE AND RESULTS) _____

Do you or have you had Diabetes Mellitus? Yes No

Do you or have you had Blood or Lymph Disease? Yes No

Do you take Corticosteroids (prednisone, cortisone)? Yes No

If yes, please explain _____

Are you taking any immunosuppressive drugs? Yes No

If yes, please explain _____

Do you have any of the following symptoms?

Fever Yes No

Tiredness/ Weakness Yes No

Night Sweats Yes No

Loss of Appetite Yes No

Unexpected Weight Loss Yes No

Cough with Phlegm Yes No

Blood Tinged Phlegm Yes No

Applicant is able to work without restrictions? Yes No

Patient is free of all communicable diseases? Yes No

If no, please explain _____

PHYSICIAN'S SIGNATURE _____

DATE _____

PHYSICIAN'S NAME (Print or Stamp) _____

LICENSE# _____

ADDRESS _____

TELEPHONE# _____