

MATCH ONE STAFFING

205-07 Hillside Avenue
 Suite# 26
 Hollis, N.Y. 11423
 Phone:[718] 217-1666
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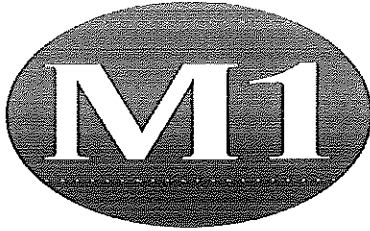
Physical Examination Report		
NAME:	DATE OF PHYSICAL:	
ADDRESS:	SOCIAL SECURITY:	
HEIGHT:	WEIGHT:	DATE OF BIRTH:

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: (HepBAG/HepBAb / 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(Forensic 10 Panel).

EVALUATION OF SYSTEMS:	Findings:	Comments / Description
Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Screening /Snellen: OD: OS: OU: Ishihara Color Blindness screening: Pass <input type="checkbox"/> Fail <input type="checkbox"/>
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	N95 Fit Test:
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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tiredness/ Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Night Sweats	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss of Appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unexpected Weight Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough with Phlegm	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Tinged Phlegm	<input type="checkbox"/> Yes	<input type="checkbox"/> 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# _____