RSN PHYSICAL EXAMINATION FORM

Date of Examination: _____ Discipline: _____

Name: _____ Date of Birth: _____

Gender: M / F Height: _____ Weight: _____ Blood Pressure: _____

Visual Acuity: Left Eye: _____ Right Eye: _____

NOTES:

ABDOMEN NORMAL / ABNORMAL _____

CARDIOVASCULAR NORMAL / ABNORMAL _____

CHEST/LUNGS NORMAL / ABNORMAL _____

ENDOCRINE SYSTEM NORMAL / ABNORMAL _____

GI-GU NORMAL / ABNORMAL _____

HEAD/EYES/EARS/NOSE/THROAT NORMAL / ABNORMAL _____

HEART NORMAL / ABNORMAL _____

LOWER EXTREMITIES NORMAL / ABNORMAL _____

LYMPHATIC SYSTEM NORMAL / ABNORMAL _____

NEUROLOGICAL NORMAL / ABNORMAL _____

SKIN NORMAL / ABNORMAL _____

SPINE-MUSCULOSKELETAL NORMAL / ABNORMAL _____

UPPER EXTREMITIES NORMAL / ABNORMAL _____

ADDITIONAL COMMENTS:

_____

_____

I have performed a physical examination on the above named individual and have found this person to be in good physical/mental health. The individual is free from any communicable diseases, does not have any medical conditions, which might interfere with the health of a client, and is able to function as a healthcare worker without restriction.

Physician's Signature: _____ M.D. #: _____

Physician's Name (please print): _____ Phone #:_____

Address: _____

We *RACE* to your *STAFFING* needs!

SUBMIT