You are required to provide the following :
1. This Health Exam Form must be completed, signed & stamped by you PCP. Must include all the lab reports pages.
2. The Quantiferon test or PPD test is required (if it comes back Positive, please request an X ray to be done and include a positive lab report copy)
3. Rubella and Rubeola lab report with titers is required.
4. A 10 panel drug screen is optional (it is not required) but your doctor must check one the last three boxes at the bottom of this form to certify you are able to work.

Care connect CDPAP Inc. **EMPLOYEE PHYSICAL EXAMINATION REPORT**

125 Ave S , Brooklyn NY 11223 tel 718-303-8998 / fax 718-228-6774 email : ay@nycareconnect.com

☐ Initial Physical Assessment ☐ Annual Assessment ☐ Return to work/LOA ☐ Other:

Name:	Marital Status:	Sex:
Address	SS #:	Title:

PHYSICAL EXAMINATION

HEAD/ENT:

EYES:

NECK:

BREASTS:

LUNGS:

CARDIOVASCULAR:

MUSCULOSKELETAL:

ABDOMEN:

GENITOURINARY:

CENTRAL NERVOUS SYSTEM:

COMMENTS

HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

LABORATORY TEST RESULTS

TEST	**DATE**	**RESULTS** PROVIDE LAB VALUES AND INTERPRETATION	
RUBELLA TITER		☐ NON-IMMUNE ☐IMMUNE **LAB VALUE:**	
MEASLES TITER		☐ NON-IMMUNE ☐IMMUNE **LAB VALUE:**	
PPD (ANNUALLY)	1. DATE IMPLANTED	1. DATE READ:	RESULTS (mmxmm):
	2. DATE IMPLANTED	2. DATE READ:	RESULTS (mmxmm):
CHEST X-RAY (+PPD)	Date:	Results:	

IMMUNIZATIONS:	DATE	DATE	DATE
RUBELLA	1.		
RUBEOLA/MEASLES	1.	2.	
HEPATITIS B VACCINE	1.	2.	3.
OTHER			

☐ I certify that he/she is free from health Impairments which could be of potential risk of the patient or might interfere with the performance of his/her duties, including habituation or addiction to depressants, stimulants , narcotics , alcohol or drugs or substances which may alter the Individuals abilities.

☐ This Individual is able to work with the following limitations:

☐ This Individual is not physically/mentally able to work. *(specify reason):*

Physician Signature: Lie. No. Date: