Shamrock Home Care
60 Katona Drive - Suite 18
Fairfield, CT 06824
Tel (203) 256-1804 Fax (203) 259-8523

Employee Physical Examination

Name:		**Date of Birth:**		**SS#:**	
Address:		**City/ State**		**ZIP Code:**	

Consent for Examination and Release of Information:

_____ _____
Signature of Applicant/Employee Date

Physical Therapist	☐	Home Health Aide	☐
Speech Therapist	☐	Registered Nurse	☐
Occupation Therapist	☐	Licensed Practical Nurse	☐
Masters in Social Work	☐	Clerical	☐

Type of Physical: ***(please check one)***

Annual *(due every 3 years)*	☐	**Return to Work**	☐	**Pre-Employment**	☐

Note to Physician:

The above named is/will be employed as a health care provider. We are interested in your medical evaluation of this person's ability to function in this capacity based upon a physical examination and significant laboratory tests. In this regard would you please complete the following:

--FOR PHYSICIAN ONLY--

Medical History

Neurological	YES	NO	If YES, indicate degree of function disability
• Seizure Disorder (Epilepsy)			
• Dizziness/Fainting			
• Weakness/Paralysis			
• Swelling of lower extremities			
Infectious Disease	YES	NO	If YES, indicate degree of function disability
• Tuberculosis			
• Hepatitis			
• Mumps			
• Measles			
• Syphilis			
• Gonorrhea			

Medical History (continued)

Drug Use/Abuse	**YES**	**NO**	If YES, indicate type and amount
• Depressants			
• Stimulants			
• Narcotics			
• Alcohol			

Physical Examination **Date of Examination_____/_____/_____**

Weight		**Height**		**Blood Pressure**	/

Check all those that apply and explain below:

Condition	Eyes	Ears	Nose	Throat	Heart	Lungs	Back
Normal							
Abnormal							

Explanation:_____

Laboratory Test (**Required)

		Date Done	Date Read	Results
• TB Skin Test (PPD) yearly				
• Chest X – Ray *(mandatory for positive PPD)*				
• Hepatitis B Vaccine Series:	Dates given			

Comments (including limitations if any):

I certify that I have conducted a physical examination on the above named person on this date and he/she is free of any communicable disease and from habituation and addition to alcohol, narcotics, stimulants, drugs or other substances, which may alter behavior. In my opinion, he/she can adequately perform the functions of a health care provider.

Date:		Physician's Name:		Physician's Signature	

Physician's Address:		Physician's Telephone #:		NPI#	

Employee Signature:		Date:	
Reviewed By:		Date:	