ONYX
HEALTH CARE STAFFING

PRE-EMPLOYMENT PHYSICAL EXAM

TO BE COMPLETED BY A LICENSED MD,DO, NP,PA,CNM

Applicant _____ **Address** _____ **DOB**_____

TO PHYSICIAN: A health examination is required for the above named person. Please enter details of all requested information. LABORATORY REPORTS MUST BE ATTACHED. Incomplete or illegible information may be rejected

- *Does applicant have any personal health considerations that may impact his/her ability to satisfactorily perform the duties given on a particular assignment (including but not limited to habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs which could alter his/her behavior?* NO☐ YES☐ If yes, please describe:_____
- ***Is Applicant in good health without restrictions or limitations? Applicant has been assessed and found to be in healthy enough to wear a mask for extended period of time if necessary*** NO☐ YES☐

MEDICAL HISTORY:

- Any major illness or health impairment _____
- Hospitalization / Serious injury _____
- Any significant finding in patient's past history? _____
- Any significant finding in patient's family's health history_____
- Allergy_____ Latex/non-medication allergies: NO☐ YES☐ If yes, please specify:_____
- Medication Currently being taken: _____

PHYSICAL EXAMINATION (notate all spaces, draw-through lines are not acceptable):

Height: _____ Weight: _____ BP: _____ Pulse: _____ Respiration: _____ Temp: _____

Immunizations: **(Please include *lab report with values*)**

Examined:	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
General Appearance			HEENT			Breasts			Abdomen		
Neurological Exam			Heart			Lymph Nodes			GU Exam		
Musculoskeletal			Lungs			Pelvic Exam			Rectal Exam		
Extremities			Neck			COMMENTS:					

- **Two (2) PPD Tests (Mantoux) or one (1) Interferon Gamma Release Assay (e.g. Quantiferon) required:**

If PPD positive, earliest date of + PPD?_____ History of BCG?Y☐ N☐ Date _____ Was Tb prophylaxis taken?N☐ Y☐

PPD Test 1: (w/in 12 months)	**PPD Test 2:** (w/in 3 months)	**Quantiferon (of other IGRA):**
Date placed:_____ Date read: _____	Date placed:_____ Date read: _____	Date: _____
Results: _____ mm ☐ NEG ☐ POS	Results: _____ mm ☐ NEG ☐ POS	Result:_____

What medication? _____ How long? _____ In your opinion what caused + PPD? _____

- **Chest X-Ray** (for + PPD or positive IGRA) Date: _____ Result:_____ ***(Chest X-ray must be attached)***
- **Rubella** antibody titer: _____ Date: _____ (***Attach Lab report)*** OR vaccine date: _____
- **Rubeola** antibody titer: _____ Date: _____ (***Attach Lab report)*** OR 2 doses of live vaccine dates:(1) _____ (2) _____ Exempt if DOB before 1957
- **Mumps** antibody titer: _____ Date: _____ (***Attach Lab report)*** OR 2 doses of live vaccine dates: (1) _____ (2) _____
- **Varicella** antibody titer: (required in all cases) _____ Date: _____ (***Attach Lab report)*** Vaccination dates: (1) _____ (2) _____ (or Declination)
- **Hepatitis B** surface antibody titer: _____ (***Attach Lab report)*** Vaccine dates:(1)_____(2)_____(3)_____(or Declination)
- **Tdap vaccine** (within 10 years) Date: _____ Lot #: _____ (or Declination)
- **Flu Vaccine** Date: _____ Lot#: _____ Mfr: _____ Expiration: _____

Physician Signature _____ Date _____

License number: _____

Physician Name printed or stamp: _____ State: _____

Telephone: _____ Address: _____