PHYSICAL STATEMENT

Employee Name (Print): _____ Date: _____

Employee Signature: _____

Employee Date of Birth: _____ / _____ / _____ Employee Social Security Number: _____

PPD (TB Test)

Date given: _____ Date read: _____ Results: _____ m

Date of Exam: _____ / _____ / _____ *(expires one year from exam date)*

Vital Signs: T _____ P _____ R _____ BP _____ Height _____ Weight _____

I have performed a physical examination on the above listed individual and have found this person to be in good physical/mental health. The individual appears to be free from any contagious diseases and is able to function as a health care professional without restrictions.

Provider's Name (Print): _____

(Physician, Certified Nurse Practitioner, or Physician's Assistant)

License Number: _____ Signature: _____

Date: _____

Address: _____

_____

Phone: _____

PO Box 5955 Florence, SC 29502 P 1.877.417.9507 F 1.866.323.0139 trinityhsg.com