**PROFESSIONAL NURSING SERVICE**

**EMPLOYEE PHYSICAL FORM**

A completed, signed Employee Health Record is required by Professional Nursing Service for healthcare employees in order to work for us. Have your primary care provider complete and sign Section B.

## A. Traveler Information

1. Full Name**:**_____

2. Date:_____

3. Are you taking any medications? YES ☐ NO ☐

4. If you answered yes so question 3, please list them here. If they are a controlled substance that will reflect on your drug screen, please include a copy of your prescritpion along with this form.

_____

Employee Signature: _____

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## B. Physical Exam – To be completed by Health Examiner

Blood Pressure: _____ Height:_____ Weight: _____

Exam Results and Comments:

_____

_____

I certify that the above person, to the best of my knowledge, is in good physical and mental health, free from symptoms indicating the presence of infectious diseases and not have any condition which would interfere with the performance of his/her duties which may require: assistance with transfers, supporting a patient during ambulation, providing personal care, and skilled nursing function.

Physician Address:_____

Date:_____

Phone Number:_____

Physician Signature: _____