CARING
HOME CARE INC.
"Better Care At Home"
Dade: (305) 947-7292 Broward: (954) 318-0747 Palm Beach (561) 424-2477 Jupiter (866) 906-5111

PHYSICAL /MEDICAL FORM

CONTRACTOR NAME_____SS#_____

MEDICAL CLEARANCE

A. Tuberculin PPD –Date Test Administered _____ Date Test Read _____
Size _____ Lot # _____

Or Chest X-Ray _____

PHYSICAL EXAMINATION

WT _____ lbs. HT_____ inches Blood Pressure_____ Pulse_____ Temp_____

SYSTEM	NORMAL	ABNORMAL	SYSTEM	NORMAL	ABNORMAL
EENT	[ ]	[ ]	Respiratory	[ ]	[ ]
Cardiovascular	[ ]	[ ]	Gastrointestinal	[ ]	[ ]
Genitourinary	[ ]	[ ]	Endocrine	[ ]	[ ]
Neurological	[ ]	[ ]	Musculoskeletal	[ ]	[ ]
Dermatological	[ ]	[ ]	Physical Abilities	[ ]	[ ]

MEDICAL STATEMENT

After examining this patient I have determined that he/she is free from malignant, communicable or mental diseases and from any illness, defect or deformity, which would impair or prevent the performance of duties, and functions or responsibility.

Physician Print Name: _____ _____
Signature of Examining Physician

Physician Phone #: _____ Date: _____
Physician address: _____
_____