Work Physical Form PDF

Employee Information

- **Name: _____**
- **Date of Birth: _____**
- **Position Applied For: _____**
- **Department: _____**

Physical Examination

- **Height: _____ Weight: _____ BMI: _____**
- **Blood Pressure: / Pulse Rate: _____**
- **Vision (Left/Right): /**

General Health

- ☐ **Fit for Work**
- ☐ **Restrictions (Please specify): _____**
- ☐ **Further Evaluation Required**

Physician's Signature: _____ Date: _____

Employee's Acknowledgement: I certify that the information provided is true and accurate to the best of my knowledge.

Employee's Signature: _____ Date: _____