Jericho Road Community Health Center
Employee Physical Form

*Notice: JRCHC **does not** allow a practitioner to attest to his/her own health status. When you submit this form, another physician **must** attest to your health status.*

In keeping with the requirements of the New York State Department of Health, I certify by my signature below that I have performed a medical evaluation on:

_____
Name of Employee

As required, the following information is provided:

1. Tuberculin Skin Test (PPD):
   ◯ Skin Test (PPD) Date Performed / /

   Results:
   ◯ Negative/**Must Be Repeated Annually** ◯ Positive/Active TB Ruled Out

   ◯ Chest X-Ray Date: _____ Result: _____

2. Excluded from requirement/No clinical signs/symptoms suggestive of active TB
   (Please check reason)
   ◯ Significant prior reaction ◯ Adequate treatment of known prior disease

   ◯ Completion of Adequate Preventative Drug Therapy ◯ Pregnancy

3. ◯ Hepatitis B Date: _____ ◯ MMR 1. Date:_____ 2. Date:_____

   ◯ Influenza Date: _____ ◯ Tetanus Date: _____

   ◯ Chicken Pox ◯ I have had chicken pox ◯ I have been immunized for chicken pox

   1. Date:_____ 2. Date: _____

I have determined that the above-named employee is free from any health impairment which is of potential risk to patients/clients which might interfere with the performance of his/her duties, including the habitation or addition to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the behavior of the individual.

Signature of Examining Practitioner: _____

Typed or Printed Name of Practitioner: _____

Date of Exam: _____