horizontal line

Pre Employment Physical Form for Nurses

**Nurse Applicant Details**

* Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Position Applied For: Nursing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History Overview**

* Past Medical History: ☐ Yes ☐ No
  + If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Allergies: ☐ Yes ☐ No
  + If yes, list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nursing Physical Assessment Checklist**

* Vital Signs: Blood Pressure: \_\_\_\_\_\_\_\_\_\_ Pulse: \_\_\_\_\_\_\_\_\_\_
* BMI Calculation: Height: \_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_
* Vision Screening: Right: \_\_\_\_\_\_\_\_ Left: \_\_\_\_\_\_\_\_ Both: \_\_\_\_\_\_\_\_
* Audiometry Test: ☐ Pass ☐ Fail
* Musculoskeletal:
  + Dexterity Test ☐ Pass ☐ Fail
  + Lifting Ability ☐ Pass ☐ Fail
* Immunization Status:
  + Hepatitis B ☐ Yes ☐ No
  + TB Test ☐ Yes ☐ No
  + MMR ☐ Yes ☐ No

**Required Screenings**

* Drug Screening: ☐ Yes ☐ No
* Tuberculosis Test: ☐ Yes ☐ No
* Fitness for Duty Assessment: ☐ Yes ☐ No

**Healthcare Provider Comments:**

**Certification by Healthcare Provider**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

**Consent by Applicant**

I affirm the accuracy of the provided information.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_