

Pre Employment Health Check Form

Date of Submission: _____

Applicant Information:

- Full Name: _____
- Contact Number: _____
- Email Address: _____
- Position Applied For: _____

Health Information:

- Have you been hospitalized in the past 12 months? Yes No
If yes, provide details: _____
- Do you have any chronic illnesses? Yes No
If yes, please specify: _____
- Do you require any accommodations to perform your job? Yes No
If yes, explain: _____

Vaccination History:

- Hepatitis B
- MMR (Measles, Mumps, Rubella)
- Tetanus
- Other: _____

Physical Examination Results (For Physician Use):

- Blood Pressure: _____
- Vision Test: _____
- Hearing Test: _____
- General Health Comments: _____

Physician's Signature: _____

Date: _____