

Work Medical Assessment Form

Employee Information

- Full Name: _____
- Employee ID: _____
- Job Title: _____
- Department: _____

Assessment Details

- Assessment Date: _____
- Reason for Assessment: _____
- Conducted By: _____

Health and Fitness Evaluation

- General Health Status: Excellent Good Fair Poor
- Ability to Perform Job Duties: Fully Capable Limited Capability Not Capable

Specific Evaluations

- Hearing: Normal Impaired
- Vision: Normal Impaired
- Physical Fitness: Meets Requirements Does Not Meet Requirements

Recommendations

- Fit for Work: Yes No
- Modifications Required: Yes No
 - If Yes, Specify:

Assessor's Details

- Name: _____
- Signature: _____
- Date: _____