



**ANNUAL PHYSICAL FORM**

EMPLOYEE NAME: \_\_\_\_\_

*(BY SIGNING THIS FORM I DO AUTHORIZE ADVANCE NURSING TO RECEIVE AND RELEASE THE FOLLOWING INFORMATION ACQUIRED IN MY RECENT MEDICAL EXAMINATION, WHICH IS RELEVANT TO MY EMPLOYMENT.)*

I HAVE EXAMINED THE ABOVE INDIVIDUAL AND TO THE BEST OF MY KNOWLEDGE HE/SHE IS IN GOOD PHYSICAL HEALTH AND MENTAL HEALTH. THIS PERSON IS FREE FROM SYMPTOMS INDICATING THE PRESENCE OF AN INFECTIOUS DISEASE AND DOES NOT HAVE ANY CONDITIONS THAT WOULD INTERFERE WITH THE PERFORMANCE OF HIS/HER PROFESSION AT FULL CAPACITY WITHOUT RESTRICTIONS.

PRIMARY CARE PROVIDER/PHYSICIAN \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

TB SCREEN DATE \_\_\_\_\_ RESULTS IN (MM) \_\_\_\_\_

CHEST FILM X-RAY \_\_\_\_\_ DATE \_\_\_\_\_ (IF TB SCREEN IS POSITIVE)

PROOF OF HISTORY – VACCINE OR TITER – Attach proof of vaccination or titer.

RUBEOLA Immunization Date \_\_\_\_\_ (or) Titer Results \_\_\_\_\_

MUMPS Immunization Date \_\_\_\_\_ (or) Titer Results \_\_\_\_\_

RUBELLA Immunization Date \_\_\_\_\_ (or) Titer Results \_\_\_\_\_

VARICELLA Hx / TITER \_\_\_\_\_

GENERAL COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Hepatitis B Dates and Declination**

- I have received the series of three vaccinations for Hepatitis-B as listed below (attach documentation):

- Date of First Injection \_\_\_\_\_  
Date
- Date of Second Injection \_\_\_\_\_  
Date
- Date of Third Injection \_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Name \_\_\_\_\_ Date

- I have not received the series of three vaccinations and I understand that due to my occupational exposure to blood or other potentially materials, I may be at risk of acquiring Hepatitis B infection. At this time I decline the hepatitis B vaccination.

\_\_\_\_\_  
Employee Name \_\_\_\_\_ Date