HEALTHCARE TRAINING & CAREER CONSULTANTS, INC.
PHYSICAL EXAMINATION FORM

NAME: ______________________ SEX: M / F BIRTHDATE: ______________

ADDRESS: ______________________ CITY: ______________ ZIP: ________

HOME PHONE: ______________________ WORK PHONE: ______________________

TO BE COMPLETED BY EXAMINING PHYSICIAN / NURSE PRACTITIONER

DESCRIBE CURRENT COMPLAINTS OR DISABILITIES PERTINENT TO THE PATIENT'S ABILITY TO PARTICIPATE IN HOME HEALTH AIDE TRAINING PROGRAM / NURSE ASSISTANT TRAINING PROGRAM. PLEASE REVIEW COURSE DESCRIPTION AND MENTAL / PHYSICAL REQUIREMENTS FOR THE PROGRAM.

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MEDICATIONS USED: PRESCRIPTION AND OVER-THE-COUNTER (USE BACK IF NEEDED)

NAME	REASON	FREQUENCY

SIGNIFICANT MEDICAL HISTORY: MAJOR, ACCIDENTS, DEFORMITIES, SURGERIES, BACK PROBLEM, HEPATITIS, OR PROBLEMS THAT MAY AFFECT THE PATIENT'S ABILITY TO PERFORM.

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EXAMINATION COMMENTS AND FINDINGS: (INCLUDE PHYSICAL AND/OR MENTAL LIMITATIONS)

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2 Steps PPD

Date of First PPD: ____________ Result: ________

Date of Second PPD: ____________ Result: ________

NOTE: 2nd PPD must be one (1) week apart.

If PPD tests positive or has a history of positive results, please document and order a chest x-ray. →

Chest X-Ray

Date of Chest X-Ray: ____________

Result: ________

THE ABOVE NAMED HAS NO DISABLING DISEASE NOR ANY HEALTH CONDITIONS THAT WOULD CREATE A HAZARD TO HIMSELF/HERSELF, FELLOW EMPLOYEES, VISITORS, OR TO PATIENTS AT THIS TIME. HE/SHE IS ABLE TO PERFORM THE PHYSICAL/MENTAL ACTIVITIES REQUIRED FOR THE PROGRAM FOR WHICH THE INDIVIDUAL IS APPLYING.

PHYSICIAN: ______________________ PHONE: ______________

ADDRESS: ______________________ CITY/STATE/ZIP ______________

SIGNATURE: ______________________ DATE: ______________

PHYSICIAN (M.D.) OR PHYSICIAN ASSISTANT

STUDENT SIGNATURE: ______________________ DATE: ______________

I GIVE PERMISSION TO RELEASE A COPY OF THIS FORM TO AFFILIATING CLINICAL FACILITY

"Doctor, Please Read Reverse Side"