Clelian Heights

135 Clelian Heights Lane • Greensburg, PA 15601-6665 • (724) 837-8120 •: fax (724) 837-6480

STAFF HEALTH APPRAISAL

To Be Completed By Employee

Name____

Address____

Phone____

Purpose of Physical Examination

__________Initial Employment __________Annual Reexamination

Type of Work Activity (Check all that apply)

_____Caring for children/adults __________Food Prep _______ Driver _____Maintenance

PART I To Be Completed By Health Professional

As shown by Physical Examination, does the individual have:

1.	At least 20/40 combined vision, corrected by glasses as needed?	YES	NO
2.	Color perception sufficient to distinguish between red, yellow, and green?	YES	NO
3.	Hearing in at least one ear at 2000, at frequencies of 500, 1000, and 2000?	YES	NO
4.	Normal blood pressure?	YES	NO
5.	Normal cardiovascular system?	YES	NO
6.	Normal respiratory system?	YES	NO
7.	Ability to climb two flights of stairs without distress?	YES	NO
8.	Normal skin?	YES	NO
9.	Normal neuromuscular skeletal systems?	YES	NO
10.	Normal endocrine system?	YES	NO

PART II

Is the individual free from communicable Tuberculosis as shown by:

Tuberculin skin testing results must be read by a MD, DO, PA, CRNP, RN or LPN

11. Date Administered ____________ Date Read __________ Negative Result YES NO

Please Print Name of Person who Read Test and Circle Credentials:

Name: ______________________________________ MD DO PA CRNP RN LPN

12. Positive skin test followed by one negative X-ray and an asymptomatic history at this health appraisal? YES NO

Please explain all "No" responses and plans for follow-up by using the reverse side of this form.

PART Ill

Does the individual have any of the following medical problems:

13.	History of heart problems?	YES	NO
14.	History of epilepsy?	YES	NO
15.	Diabetes?	YES	NO
16.	Thyroid or other metabolic disorders?	YES	NO
17.	Obesity?	YES	NO
18.	Disabling emotional disorder?	YES	NO
19.	Current drug or alcohol dependency?	YES	NO
20.	Other special medical problems which require restriction of activity?	YES	NO
21.	Medications which might affect work capacity?	YES	NO

Explain all "Yes" responses giving plans for follow-up below.

PLEASE PRINT:

Physician's Name ____

Address ____

____

____

Telephone ____

Date of exam ____

The above named person was examined this date and was found to be free on any communicable or infectious disease and to be without any physical or mental condition that would be a hazard to persons being cared for in a facility regulated or supervised by the Department of Public Welfare, or affect the duties required in the performance of his/her work.

Signature of Physician ____