



PHYSICAL EXAM (To be completed by physician/licensed practitioner)

Name (Please Print) First Middle Last

Date of Physical Exam: _____ / _____ / _____

The above named patient has been examined by me and found to be in good physical and mental health, free of communicable disease and able to perform the functions of the position without restrictions.

Physician's/Licensed practitioner Signature: _____ Date: _____ / _____ / _____

Physician's/Licensed practitioner Name: _____ License #: _____
(Please Print)

Address: _____

City: _____ State: _____ Zip: _____

TB/PPD FORM

Name (Please Print) First Middle Last

Test Placed: Right Arm Left Arm

By: _____ Date: _____ / _____ / _____

Test Read (between 48-72 hours later)

_____MM

By: _____ Date: _____ / _____ / _____

Negative: _____ Positive: _____

Date of Chest Xray: _____ / _____ / _____
(Please attach proof of Chest Xray)