



Statement of Physical Health
(To be completed within 30 days of hire)

Patient: _____

Physician: _____ or Nurse Practitioner: _____
(Print Name) (Print Name)

Practice Address: _____

Date: _____

This is to certify that I have completed a physical examination and have determined that
_____(Individual's Name)_____ possesses the minimum physical abilities to perform
the proposed duties of a _____
Position (Title)

He/she has documented proof of immunization against/immunity to rubeola, rubella, mumps,
measles, varicella, tetanus and hepatitis B and does not have an active infectious condition which
might place others at risk.

The above named individual is medically qualified to wear an air-purifying respirator in the
performance of their duties.

The following immunization history has been obtained:

PPD Results: _____ or Chest X-ray results: _____ Date: _____

MMR History: _____ or Immunization History: _____ or Titer: _____

HepB Heptavax _____ or Documented immunity: _____ or Waiver: _____

Varicella History: _____ or Immunization History: _____ or Titer: _____

Date of last Tetanus Vaccination: _____(Required every 10 years)

Signed: _____ M.D./D.O./N.P. Date: _____