



Kahu Malama Nurses, Inc.

EMPLOYEE PRE-EMPLOYMENT PHYSICAL EVALUATION



Applicant/Employee Name: _____

Classification: _____

I. HISTORY - Applicant Please complete Part I during initial application!

- | | | | |
|--|---|---|---|
| Yes No | Yes No | Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Asthma/Bronchitis | <input type="checkbox"/> <input type="checkbox"/> Hypertension | <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Back/Spinal Problems | <input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> <input type="checkbox"/> Cancer |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Allergies | <input type="checkbox"/> <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Audio/Visual Problems | <input type="checkbox"/> <input type="checkbox"/> _____ | <input type="checkbox"/> <input type="checkbox"/> _____ |

If "yes", explain: _____

	HISTORY OF DISEASE	VACCINE	BLOOD TITRE	DATE	RESULT
TB/ Skin Test or X-Ray					
Varicella (Chicken Pox)					
Rubeola (Measles)					
Rubella (German Measles)					
Hepatitis B	Vaccine #1				
	Vaccine #2				
	Vaccine #3				
Diphtheria Tetanus Vaccine					

(Please attach copies of results if available)

Employee Signature

Date

II. PHYSICIAN STATEMENT

The above named individual has been examined by me and found to be in good physical and mental health, free of any communicable diseases, and able to meet the demands of his/her profession at full capacity.

Did the Exam include any of the following?

- | | | |
|--|---|---|
| Yes No | Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> Complete Blood Count | <input type="checkbox"/> <input type="checkbox"/> Complete Urinalysis | <input type="checkbox"/> <input type="checkbox"/> Stool Culture |
| <input type="checkbox"/> <input type="checkbox"/> Chest X-ray | <input type="checkbox"/> <input type="checkbox"/> PPD Skin Test | <input type="checkbox"/> <input type="checkbox"/> Hepatitis B Screening |

Work Restrictions? Yes ___ No ___ If "yes" explain: _____

May safely wear HEPA mask? Yes ___ No ___ If "no" explain: _____

Physician, Nurse Practitioner or Physician's Assistant

Date

Name (Please Print)

Telephone

Address

KMN Form 200-06 (EE Physical Eval)