



Specializing in Healthcare Staffing Since 1995
 6400 N. Andrews Ave., Suite 440, Ft. Lauderdale, FL 33309

Physician Statement

This form is to be completed by your Examining Physician:

Employee Name: _____ Date _____
 SSN _____ Date of Birth _____ Age _____

Health History: Check off which conditions apply.

	Yes	No		Yes	No
Asthma	_____	_____	Nervous Stomach	_____	_____
Kidney	_____	_____	Rheumatic Fever	_____	_____
Tuberculosis	_____	_____	Muscular disease	_____	_____
Syphilis	_____	_____	Psychiatric disease	_____	_____
Gonorrhea	_____	_____	Cardiovascular disease	_____	_____
Diabetes	_____	_____	Gastrointestinal ulcer	_____	_____
Head or spinal injuries	_____	_____	Seizures, fits, convulsions	_____	_____
Extensive confinement	_____	_____	Any nervous disorder	_____	_____
Permanent defect from illness,	_____	_____			

If yes to any of the above conditions, please explain _____

Temperature _____ Pulse _____ Respiration _____ Blood Pressure _____
 Height _____ ft _____ in. Weight _____ lbs.

<u>Eyes</u>			<u>Heart</u>			Upper Extremity	NL	AB
Globe	NL	AB	Rhythm	NL	AB	Hands/Fingers	NL	AB
Pupils	NL	AB	Auscultation	NL	AB	Legs	NL	AB
			Abdomen	NL	AB	Knees	NL	AB
<u>Ears</u>			Abd. Surg. Scar	NL	AB	Feet/ankles	NL	AB
Canal Clear	NL	AB				Varicosities	NL	AB
TM Visualized	NL	AB	<u>Hernia</u>			Up. Ext. strength	NL	AB
			Umbilical	N	Y	Up. Ext. ROM	NL	AB
<u>Nose</u>	NL	AB	Inguinal	N	Y	Low. Ext. strength	NL	AB
			Femoral	N	Y	Back/spine ROM	NL	AB
<u>Mouth</u>			Varicocele	N	Y	Back surg. Scar	N	Y
Teeth	NL	AB						
Throat	NL	AB	<u>Reflexes</u>			<u>Sensory Examination:</u>		
			Pupillary Rt	NL	AB	Up. Ext. Rt.	NL	AB
<u>Skin</u>	NL	AB	Lt	NL	AB	Lt.	NL	AB
<u>Neck</u>	NL	AB	Knee Rt	NL	AB	Low. Ext. Rt.	NL	AB
<u>Thyroid</u>	NL	AB	Lt	NL	AB	Lt.	NL	AB
<u>Chest Wall</u>	NL	AB						
<u>Lungs</u>	NL	AB						

The person named above has been examined by me and found to be in good physical and mental health, free from communicable disease and able to function as a nurse at full capacity. The above information is true to the best of my knowledge. I hereby authorize _____ and its licensed physicians to release this Physical Examination Report to _____.

Examining Physician _____ **Date** _____