



Staff Relief Inc.

Physical Examination

(to be completed by Primary Care Provider)

Please PRINT this form out, get it filled out by your Primary Care Provider & return to complete your application.

Name: _____ Date: _____

Height: _____ Weight: _____

Vital Signs: P _____ R _____ BP _____

Mumps: _____
(if available)

Rubella: _____
(if available)

Rubeola: _____
(if available)

(Proof of history vaccine, or aged out)

TB Screen: _____ Date: _____ Positive or Negative

Chest X-Ray: _____ (if positive TB Screen) Date: _____

General Comments: _____

I certify that the above person is free from symptoms indicating the presence of an infectious disease and does not have any condition which would interfere with the performance of his/her duties which may require: assistance with transfers; supporting patients during ambulation; providing personal care; light housekeeping; shopping; laundry; skilled nursing functions and any and all other duties as required to be performed in the capacity of a licensed nurse.

Print Primary Care Provider's Name

Primary Care Provider's Signature
or Health Dept

Date

Date

Office Hours - Monday thru Friday 8:00 am - 5:00 pm. After Hours & Weekends: Answering Service 770-358-6006