Work Physical Form

Date of Exam:			
Employee / Applicant Information			
Name:		Date of Birth:	
Gender:	Male Female Other:		
Address:			
Email:		Contact No.	
Job Title/Position:		Department:	
Medical History			
Known Allergies		Current Medications	
Chronic Conditions or Ongoing Treatment		Previous Surgeries / Hospitalizations	
Physical Examination			
Height:		Weight:	
Blood Pressure:		Heart Rate:	
Vision Test:		Hearing Test:	
Musculoskeletal Assessment			
☐ Normal Abnormal			
Additional Tests			
Drug Screening: ☐ Negative ☐ Positive:	TB Test: ☐ Negative ☐ Positive	Other Tests:	

Fit for Work
☐ The employee/applicant is fit for work with no restrictions.
☐ The employee/applicant is fit for work with the following restrictions:

Physician’s Information		
Name:	License Number:	Phone / Email:

Physician's Signature

Employee / Applicant's Signature