C.A.R.E.S.
Community And Residential Empowerment Services

105 West Broad Street
Suite 200
Tamaqua PA 18252
P 570-225-7360
F 570-225-7361

TO: All Prospective and Current C.A.R.E.S. Employees
RE: Physical Examinations

All new employees are required to have a physical examination after being offered a position with C.A.R.E.S. and prior to attending orientation. C.A.R.E.S. must receive results of the physical examination and Mantoux tests prior to orientation. Physical examination results will be kept confidential. The initial physical examination is at the expense of the individual and individuals can choose what physician they would like to perform the physical examination.

Physical examinations must include:

- General physical examination
- Mantoux test
- Clearance to perform the essential functions of the job as indicated in the job description
- Statement indicating patient is free from communicable diseases or is aware of the precautions necessary to protect others
- Signature of Physician

Subsequent physical examinations and Mantoux tests are required in accordance with your specific C.A.R.E.S. policy and licensing requirements.

Chest x-rays are ordered as a result of a reaction to a Mantoux test. No additional testing is required by C.A.R.E.S. Except for random drug screens as assigned, any other testing performed will be at your expense and will not be reimbursed.

Please contact Human Resources at 570-225-7360 if you have any questions.

C.A.R.E.S.
Community And Residential Empowerment Services

105 West Broad Street
Suite 200
Tamaqua PA 18252
P 570-225-7360
F 570-225-7361

Employee Physical Evaluation Report

Employee Information *(to be completed by employee)*

Last Name: _____ First Name: _____ Date: _____

Age: _____ Sex: _____ Social Security Number: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

In Case of Emergency, Please Notify: _____ Phone: _____

Personal Physician Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Health History *(to be completed by employee)*

Name: _____ Date of Birth: _____

Allergies/Contraindicated Medications: _____

Current Medications: _____

_____

Immunizations *(this **must** be filled out in it's entirety including dates if answered Yes)*

Type	Yes	Date of Immunization	No	Type	Yes	Date of Immunization	No	Type	Yes	Date of Immunization	No
Flu				Measles				Polio			
Tetanus				Mumps				Hepatitis			
Diphtheria				Rubella				Other			

Health over the last year: _____

_____

_____

Chronic Conditions/Present Illnesses: _____

_____

_____

C.A.R.E.S.
Community And Residential Empowerment Services

105 West Broad Street
Suite 200
Tamaqua PA 18252
P 570-225-7360
F 570-225-7361

Please check any symptoms or conditions that you have experienced:

Seizures		Chorea		Hypertension		Diabetes		Stroke	
Rheumatic Fever		Cancer		Drug Allergy		Asthma		Back Injury	
Hepatitis		Mumps		Tonsillitis		Typhoid		Meningitis	
Diphtheria		TB		Measles		Pneumonia		Other	

Please describe any checked items: _____

_____

Previous surgery or hospitalizations/other conditions: _____

_____

Have you filed or been treated for a work-related injury with any past employer? _____ Yes _____ No

If yes, please list all injuries, dates, employers: _____

_____

Patient Authorization/Certification

I, the undersigned, do hereby certify that the information provided on this form is true to the best of my knowledge and understand that any falsification, misrepresentation or omission, concerning permission for the results of my medical examination and for the personal medical history, including but not limited to any and all information related to drug/alcohol use, abuse and or treatment and/or mental health diagnosis and or treatments that I have completed, to be transmitted to the relevant personnel.

Signature: _____ Date: _____

Printed Name: _____

C.A.R.E.S.
Community And Residential Empowerment Services

105 West Broad Street
Suite 200
Tamaqua PA 18252
P 570-225-7360
F 570-225-7361

Clinical Evaluation *(to be completed by physician)*

Last Name: _____ First Name: _____ Date: _____

Height: _____ Weight: _____ Blood Pressure: _____

Please check each item:

Area	Normal	Abnormal	Describe Abnormal Findings
Head/Neck			
Eyes			
Ears			
Nose			
Mouth			
Throat			
Teeth			
Chest/Lungs			
Breasts			
Heart			
Abdomen			
Hernia			
Arms			
Hands			
Legs			
Feet			
Spine			
Skin			
Lymph Nodes			
Neurological			

Clinical Impressions/Work Restrictions *(to be completed by physician)*

As far as can be determined from this examination, is the patient able to perform the job duties as described?

_____ Yes _____ No

As far as can be determined from this examination, is the patient` free and clear of all communicable diseases and/or medical problems which might interfere with the health, safety, or well-being of other individuals?

_____ Yes _____ No

If no, what precautions need to be taken or what other information is necessary to ensure the health/safety of other individuals? _____

_____

C.A.R.E.S.
Community And Residential Empowerment Services

105 West Broad Street
Suite 200
Tamaqua PA 18252
P 570-225-7360
F 570-225-7361

Laboratory Work Ordered *(to be completed by physician)*

Mantoux test location: _____Mantoux test result: _____

Date applied: _____ Date read: _____

_____ _____
Signature of Physician, Certified Nurse, Practitioner or Registered Assistant Date

Print or Stamp Name _____
Address _____
City, State, Zip _____