Kaweah Health
MORE THAN MEDICINE. LIFE.

POST- OFFER/ PRE-PLACEMENT PHYSICAL EVALUATION

(EMPLOYEE TO COMPLETE)

Health History

Name: _____ SSN: _____-_____-_____ Phone: _____-_____-_____

Address: _____ City: _____ Zip: _____

Birth Date: (MM/DD/YYYY): _____/_____/_____ Department: _____ Position: _____

Family Physician/ Clinic: _____

Physical Requirements/ Health History:

Please review Physical Demands and Job Description

		Yes	No
1.	Can you meet the essential functions/physical demands of your position with or without reasonable accommodation/s?	☐	☐
2.	Have you ever had a work-related injury or illness that would prevent you from meeting the physical requirements of this job?)	☐	☐
3.	Do you have any physical restrictions?	☐	☐
4.	Are you presently under a doctor's care for any condition related to your position?	☐	☐
5.	Have you ever been hospitalized for any condition related to your position?	☐	☐

Please provide details for all "Yes" answers given above in items 2-5 OR "No" for question 1:

_____

_____

_____

_____

Do you have any problems with the following related to the position? (Check "Yes" or "No")

		Yes	No			Yes	No			Yes	No
1.	Vision	☐	☐	6.	Shoulder pain /injury	☐	☐	11.	Foot pain/ injury	☐	☐
2.	Hearing	☐	☐	7.	Skin Problem	☐	☐	12.	Ankle pain/ injury	☐	☐
3.	Yellow Jaundice or Hepatitis	☐	☐	8.	Chronic Rash	☐	☐	13.	Knee pain/ injury	☐	☐
4.	Hand/ Wrist pain/ injury	☐	☐	9.	Hernia	☐	☐	14.	Broken Bone	☐	☐
5.	Neck pain/ injury	☐	☐	10.	Low back pain/ injury	☐	☐	15.	Neck pain/ injury	☐	☐

Have you ever had an allergy or reaction to the following? (Check "Yes" or "No")

		Yes	No			Yes	No
1.	Allergy to Latex	☐	☐	4.	Allergy to foam pillows	☐	☐
2.	Allergy to Rubber gloves	☐	☐	5.	Any other allergic reaction, sensitivity or rash related to the position	☐	☐
3.	Allergy to Bandages	☐	☐				

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Immunization Records

Please provide your immunization records. If you do not have a copy please visit, myvaccinerecord.cdph.ca.gov to request records.

Tuberculosis History:

For individuals with PPD reactor- Please provide an x-ray report if completed within the last 12 months

Type (please circle one)	Date/s Given within the last 12 months	Date/s Read	Results
PPD/ TB (valid if 2 tests results are provided: (1) within the last 12 months and (1) within the last 12 weeks)			
Quantiferon Gold Blood Test (valid test if completed within the last 12 weeks)			
Chest X-ray (valid within the last 12 months)			
If reactor, was treatment received? Yes No N/A			
If yes type of treatment received:			
TB Vaccine (BCG) recipient? Yes No N/A Country:			

Health Care Personnel (HCP)
Baseline Individual TB Risk Assessment

Temporary or permanent residence of ≥1 month in a country with a high TB rate **Yes** ☐ **No** ☐
Any country other than the United States, Canada, Australia, New Zealand,and those in Northern Europe or Western Europe

Current or planned immunosuppression, **Yes** ☐ **No** ☐
including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

Close contact with someone who has had infectious TB disease since the last TB test **Yes** ☐ **No** ☐

I certify that the above answers are true, and hereby give the examining practitioner permission to submit a report of my physical condition to Kaweah Health.

Signature_____ **Date**_____