PROVISIONS
Home Healthcare Services, LLC

Physical Assessment Form

Date: _____ (Must be within 1 year of date listed)

I certify that _____is in overall good physical and mental health and is free from any communicable diseases. He/She can fulfill all duties of his/her job as a_____

Does the individual listed above have any restrictions with any of the following activities?

Activity	**Yes**	**No**	**Comments**
Sitting			
Standing			
Lifting over 35 lbs.			
Walking			
Kneeling			
Squatting			
Pushing/Pulling			
Bending			
Transferring a person over 50 lbs. with assistance			

Does the individual listed above have any restrictions involving any of the following systems?

Body System	**Yes**	**No**	**Comments**
Visual			
Auditory			
Respiratory			
Cardiovascular			
Integumentary			
Digestive/Urinary			
Psychological			

Tuberculosis Clearance

(2 Steps-PPD Required)

Step 1

PPD administered on _____ Site: LA____ RA____

Administered by _____

Lot # _____ Expiration date: _____

PPD read on _____ Read by_____

Result: _____ mm

Step 2

PPD administered on _____ Site: LA____ RA____

Administered by _____

Lot # _____ Expiration date: _____

PPD read on _____ Read by_____

Result: _____ mm

Chest X-Ray: Yes____ No____. If yes, please attach report

Date_____

QuantiFeron (R) Gold: Yes____ No____. If yes, please attach report

Date_____

Additional Comments: _____

Physician name: _____ Signature: _____

License number: _____ Address: _____

If using stamp, place here