Job Placement Examination

Patient Name:_____ **DOB:**_____ **Date:**_____

Address:_____

Phone Number:_____ **Age:**_____ **Sex:**_____

Company Name:_____

Position:_____

Specific Job Demands:

Hours per day sitting:_____ Hours per day standing:_____ Hours per day walking:_____

Hours per day bending:_____ Hours per day requiring repetitive hand motion:_____

Average number of times per day requiring climbing:_____

Maximum amount of weight lifted:_____ Average number of times per day lifting this weight:_____

Average amount of weight lifted:_____ Average number of times per day lifting this weight:_____

BASED ON THE ABOVE JOB DEMANDS AND THE REQUIREMENTS OF THE COMPANY, THE FOLLOWING TESTS ARE REQUIRED WITH THIS PHYSICAL EXAMINATION:

	YES	NO	Guidelines for physical requirement and/or further investigation
HISTORY AND PHYSICAL EXAM			Positive findings must not place patient at risk while performing the above job
URINALYSIS			Sugar or protein in urine must be followed up with blood examination
URINE DRUG SCREEN			All positive findings are followed up by MRO
BACK ASSESMENT EXAM			Grade 4-8 pass without restrictions Grade 8-12 must undergo further investigation as required by the company
LUMBAR X-RAY			Positive findings require further investigation
CHEST X-RAY			Positive findings require further investigation
ELECTROCARDIOGRAM			Positive findings require further investigation
PULMONARY FUNCTION TEST			Positive findings require further investigation
T. B. TINE TEST			Positive findings require further investigation
AUDIOGRAM TEST			Positive findings require further investigation

Medical History

If you answer yes to any of these questions, please provide more information in the comments area below.

1. Do you have any physical or mental impairment which would prevent you from performing this job?
   Yes No
2. Are you currently receiving disability payments? **Yes No**
3. Have you ever been injured at work? **Yes No**
   If Yes, How many times?_____ Did you receive Workman's Compensation? **Yes No**
   Type of injury: **Bone Joint Muscle Back Hernia Cut Burn**
4. Have you ever worked the toxic materials? **Yes No**
5. Have you ever had an injury to your back? **Yes No**
6. Have you ever been refused employment for health reasons? **Yes No**
7. Have you ever used non-prescription controlled drugs? **Yes No**
   If yes, What? **Cocaine PCP Marijuana LSD/Acid Other:**_____
8. Do you now, or have you ever:
   a. Smoked Cigarettes? **Yes No** If yes, pack per day: **½ 1 2 3 Quit When?**_____
   b. Used alcohol? **Yes No** If yes, **Daily Weekly Monthly Other:** _____
   c. Had an allergic reaction to medication? **Yes No** If yes, **Medication Name:** _____
   d. Had an injury that required hospitalization? **Yes No**
   e. Had surgery? **Yes No**
9. Have you ever had:

Arthritis	Yes	No	Back spasm or pain	Yes	No
Epilepsy	Yes	No	Sciatica	Yes	No
Chronic cough	Yes	No	Ruptured disc	Yes	No
Fainting spells	Yes	No	Fractured vertebrae	Yes	No
Headaches	Yes	No	Leg numbness	Yes	No
Numbness of the			Abnormal back x-ray	Yes	No
hands or feet	Yes	No	Hernia	Yes	No
Double vision	Yes	No	Frequent diarrhea	Yes	No
Seizures	Yes	No	Stomach ulcers	Yes	No
Paralysis	Yes	No	Diabetes	Yes	No
Head injury	Yes	No	Stroke	Yes	No
Asthma	Yes	No	Kidney disease	Yes	No
Hay fever	Yes	No	Anemia	Yes	No
Shortness of breath	Yes	No	Liver disease	Yes	No
Tuberculosis	Yes	No	Psychiatric disorders	Yes	No
Emphysema	Yes	No	Cancer	Yes	No
Abnormal chest X-ray	Yes	No	Thyroid disease	Yes	No
High blood pressure	Yes	No	Muscular disease	Yes	No
Heart trouble	Yes	No			
Heart attack	Yes	No			

Comments:_____

_____

_____

_____

Provider Signature:_____ **Date:**_____

Patient Signature: _____ **Date:**_____

Physical Examination

Patient's Name:_____ **Date:**_____

Height:_____ **Weight:**_____ **Temp:**_____

Pulse:
Resting_____ After exercise_____

Blood Pressure: _____
Repeat Blood Pressure:
Date:_____ Pressure:_____

Hearing:
Whisper
R_____ L_____
Audiometric Test
Pass____ Fail____

Vision: Wears glasses or contacts **Yes** **No**
Eye Chart:

Without glasses:
Dist. Right 20/____
Dist. Left 20/____
Dist. Both 20/____
Near Right 20/____
Near Left 20/____
Near Both 20/____

With Glasses:
Dist. Right 20/____
Dist. Left 20/____
Dist. Both 20/____
Near Right 20/____
Near Left 20/____
Near Both 20/____

Color Vision field:
Normal____ Abnormal____

Peripheral Perception:
Pass____ Fail____

Depth Perception:
Pass____ Fail____

Laboratory Findings:

Urinalysis:
Sugar ____Neg ____Pos
Protein ____Neg ____Pos

	Normal	Abnormal Findings
Skin		
Eyes		
Ears		
Nose		
Neck		
Glands		
Chest		
Lungs		
Heart		
Abdomen		
Urinary		
Upper Ext		
Lower Ext		
Scars		
Joints		
Hernia		
Loss of Limbs		
Bends to touch floor		
Neurological		
Sensation		
Motor		
Reflex		
Coordination		

Comments:_____
_____
_____
_____
_____
_____

Patient's Name: _____ Date of Birth: _____

❑ I have made the examination above and find this applicant fit to perform the essential job functions as listed on page one of this physical.

❑ I have made the examination above and find this applicant fit to perform the essential job functions on page one of this physical only is the following accommodation can be made:

_____

_____

❑ I have made the examination above and I find I must defer recommendation of this applicant pending:

_____

_____

❑ I have made the examination above and found this applicant presents a direct threat to them, or others, based on the physical requirements of the position and the positive physical findings within physical examination.

Provider Signature:_____ Date:_____