COTTAGE HOMECARE SERVICES
25 Newbridge Road, Ste. #302, Hicksville, NY 11801
Tel: 516.367.2266 • Fax: 516.367.1067

EMPLOYEE PHYSICAL EXAMINATION REPORT

☐ Pre-Employment Physical Assessment ☐ Annual Assessment ☐ Return to Work/LOA ☐ Other

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize _____ to release all health information about me to Cottage Homecare Services, Inc.

Employee Signature: _____

DEMOGRAPHIC INFORMATION

First Name: _____ Last Name: _____ Sex: M ☐ F ☐ DOB: _____

Date of Exam: _____ Address: _____

SSN: _____ Marital Status: M ☐ S ☐ W ☐ D ☐ E-Mail: _____

PHYSICAL EXAMINATION

HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

PHYSICAL CONDITION	EXPERIENCING ANY OF THE SYMPTOMS BELOW?
Head/ENT:	Weakness:
Eyes:	Fatigue:
Neck:	Lack of Appetite:
Breasts:	Weight Loss:
Lungs:	Fever:
Cardiovascular:	Night Sweats:
Muscular/Skeletal:	Chest Pains:
Abdomen:	Shortness of Breath:
Genitourinary:	Persistent Cough:
Neurological:	Blood-Streaked Sputum:

LABORATORY RESULTS (ALL LAB REPORTS AND RESULTS MUST BE ATTACHED)

TEST	DATE PERFORMED	RESULTS		LAB VALUE
Rubella Titer	___/___/_____	☐ Immune ☐ Not Immune		
Rubeola/Measles Titer	___/___/_____	☐ Immune ☐ Not Immune		
Mumps Titer	___/___/_____	☐ Immune ☐ Not Immune		
PPD or QFT (circle one)	___/___/_____	☐ Positive ☐ Negative		DATE READ: ___/___/_____
Chest X-Ray (if positive)	___/___/_____	☐ Positive ☐ Negative		DATE READ: ___/___/_____
Drug Screening	___/___/_____	Results: _____		
Hepatitis B	IMMUNIZATION DATES:	1. ___/___/_____	2. ___/___/_____	3. ___/___/_____

☐ This individual is free from any health impairment that is a potential risk to the patient or another employee of which may interfere with the performance of his/her duties including the habituation or addiction to drugs or alcohol.

☐ This individual is able to work with the following limitations: _____

☐ This individual is NOT physically/mentally able to work (specify reason): _____

Physician Name: _____ Physician Signature: _____ Date Signed: _____

Physician License No: _____ Physician Stamp: _____