Morningstar Home Health Agency, Inc.

MEDICAL EXAMINATION CERTIFICATE

Date:________________

Name: ____________________________________ Sex: __________________ Marital Status: _________

Address: ____ Telephone: ____________

The following information is required by the Department of Health, Title XXII, Chapter I, Section 70723, for all persons working in the health field:

PHYSICAL EXAMINATION (to be completed by physician)

Height	Weigh	Blood Pressure	Pulse
________	________	________	________

Physical Exam:

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MANTOUX Test Result __________________________

Chest X-ray (If indicated) ______________ EKG (if indicated) ________________ Date _______

Urinalysis ____

VDRL (RPR) ____________________ Other Lab/Results _________________________

Any Communicable Disease:

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I have examined the above-named individual and I certify that he/she is mentally and physically able to perform the duties of his/her job. I further certify that he/she is free from communicable disease.
I further certify that he/she does not appear to be at risk of transmitting communicable disease.

Physician's Name ____________________ Physician's Signature______________ Date __________

Physicians Address ____________________ Telephone ________________________

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