LOVE RESPECT AND CARE
HOME HEALTH AIDE

YEARLY PHYSICAL

Patient Name		Date	

THIS SECTION TO BE COMPLETED BY EMPLOYER		
This physical examination is for the purpose of employment in Direct Care Work. Activities may include:		
Lifting	**Sitting**	**Walking**
Driving	**Food Preparation**	**House Chores**
Hoyer Lift Transfers	**Bed Transfers**	**Wheelchair Transfers**
Other:		

SECTION TO BE COMPLETED BY PHYSICIAN, PHYSICIAN'S ASSISTANT OR CERTIFIED REGISTERED NURSE PRACTITIONER (CRNP)		
1.	**DID YOU CONDUCT A PHYSICAL EXAMINATION?** ☐ **YES** ☐ **NO** The physical examination should include a functional assessment of vision and hearing and a systems review looking for conditions that might affect performance or predispose this individual to occupational injury relating to the type of activities required by the job (see type of job listed above).	
2.	**DID THIS INDIVIDUAL HAVE ANY COMMUNICABLE DISEASES?** ☐ **YES** ☐ **NO** If yes, attach separate sheet(s) to describe the conditions and the risk it might pose to others exposed to this individual.	
3.	**BASED ON YOUR FINDINGS FOR #1 AND #2 ABOVE AND OTHER INFORMATION GATHERED DURING YOUR EXAMINATION, IS THIS INDIVIDUAL SUITABLE TO PROVIDE DIRECT CARE WORK?** ☐ **YES** ☐ **NO**	
	IF YOU ANSWERED "NO" TO QUESTION #3, please list any information regarding this individual's medical condition or other information gathered during your examination that might threaten the health of our/their client.	

Physician's Name **Signature** **Date**

Address **Telephone Number**