PEARLCARE MEDICAL STAFFING, LLC.

Physician's Statement

Employee Name _____ Date _____ Telephone _____

Street Address _____ City _____ State _____ Zip _____

Physician's Name _____ Office/Company Name _____ Telephone _____

Date of last Physical Examination_____

PPD Skin Test Results (req. q 1 year) □ Positive □ Negative Date_____
Chest X-Ray (req. if + PPD) □ Positive □ Negative Date_____
BCG Value □ Positive □ Negative Date_____

Rubeola Titer (Measles) _____/_____
Titer Value/Immune/Date Vaccine/Date

Rubella Titer (German Measles) _____/_____
Titer Value/Immune/Date Vaccine/Date

Mumps Titer _____/_____
Titer Value/Immune/Date Vaccine/Date

Varicella Titer (Chicken Pox) _____/_____
Titer Value/Immune/Date Vaccine/Date

Hepatitis B (Titer or Vaccine) _____/_____/_____/_____
Initial Date Date (4 weeks) Date (6 Mos.) Titer Value

I. Does the individual have any physical limitations?_____
_____

II. Does the individual take any prescribed medications?_____
_____

III. Which of the following have you had since your last review?

Weight Gain/Loss_____lbs.	Y	N	Change in bowel habits	Y	N
Change in Vision	Y	N	Black/bloody/stool	Y	N
Frequent cough/night sweat/chills	Y	N	Persistent diarrhea	Y	N
Recurrent fever	Y	N	Burning/blood in urine	Y	N
Generalized swollen glands	Y	N	Problem Urinating	Y	N
Indigestion/difficulty swallowing	Y	N	Muscle or joint pain	Y	N
Hoarseness	Y	N	Low back pain	Y	N
Difficulty breathing	Y	N	Breast lump/discharge	Y	N
Palpitation/irregular heartbeat	Y	N	Skin rash/sores or lumps	Y	N
Pain/pressure in chest	Y	N	Dizziness	Y	N

I have determined that the above is free from any physical and mental impairment which if of potential risk to patients or which might interfere with the performance of the person's duties, including but not limited to, the habituation of addiction to depressants, stimulants, narcotics, alcohol, or other drugs or "substances" which may alter the individual's behavior.

X_____
Signature of Physician Date Physician's Stamp with License #