



**Statement of Physical Health**  
**(To be completed within 30 days of hire)**

Patient: \_\_\_\_\_

Physician: \_\_\_\_\_ or Nurse Practitioner: \_\_\_\_\_  
(Print Name) (Print Name)

Practice Address: \_\_\_\_\_

Date: \_\_\_\_\_

This is to certify that I have completed a physical examination and have determined that \_\_\_\_\_ possesses the minimum physical abilities to perform  
(Individual's Name)

the proposed duties of a \_\_\_\_\_  
Position (Title)

He/she has documented proof of immunization against/immunity to rubeola, rubella, mumps, measles, varicella, tetanus and hepatitis B and does not have an active infectious condition which might place others at risk.

The above named individual is medically qualified to wear an air-purifying respirator in the performance of their duties.

The following immunization history has been obtained:

**PPD** Results: \_\_\_\_\_ or Chest X-ray results: \_\_\_\_\_ Date: \_\_\_\_\_

**MMR** History: \_\_\_\_\_ or Immunization History: \_\_\_\_\_ or Titer: \_\_\_\_\_

**HepB** Heptavax \_\_\_\_\_ or Documented immunity: \_\_\_\_\_ or Waiver: \_\_\_\_\_

**Varicella** History: \_\_\_\_\_ or Immunization History: \_\_\_\_\_ or Titer: \_\_\_\_\_

Date of last **Tetanus Vaccination**: \_\_\_\_\_ (Required every 10 years)

Signed: \_\_\_\_\_ M.D./D.O./N.P. Date: \_\_\_\_\_