# Infinity Healthcare Services, LLC

Revised 11/14/2019

## ANNUAL PHYSICAL EXAMINATION FORM

Part One: TO BE COMPLETED BY CAREGIVER / APPLICANT

Name: _____ Date of Exam: _____

Address: _____ Date of Birth: _____

Sex: ☐Male ☐Female Name of Accompanying Staff: _____

**Allergies/Sensitivities:** _____

EVALUATION OF SYSTEMS

**Blood Pressure: _____/_____ Pulse: _____Respirations: _____ Temp: _____ Height: _____ Weight: _____**

| System Name | Normal findings? | Comments/Description |
|---|---|---|
| Eyes | ☐ Yes ☐ No | |
| Ears | ☐ Yes ☐ No | |
| Nose | ☐ Yes ☐ No | |
| Mouth/Throat | ☐ Yes ☐ No | |
| Head/Face/Neck | ☐ Yes ☐ No | |
| Breasts | ☐ Yes ☐ No | |
| Lungs | ☐ Yes ☐ No | |
| Cardiovascular | ☐ Yes ☐ No | |
| Extremities | ☐ Yes ☐ No | |
| Abdomen | ☐ Yes ☐ No | |
| Gastrointestinal | ☐ Yes ☐ No | |
| Endocrine | ☐ Yes ☐ No | |
| Musculoskeletal | ☐ Yes ☐ No | |
| Integumentary | ☐ Yes ☐ No | |
| Renal/Urinary | ☐ Yes ☐ No | |
| VISION SCREENING | ☐ Yes ☐ No | Is further evaluation recommended by specialist? ☐ Yes ☐ No |
| HEARING SCREENING | ☐ Yes ☐ No | Is further evaluation recommended by specialist? ☐ Yes ☐ No |
| Do you have visual, Hearing or other physical Limitations | ☐ Yes ☐ No | |
| Is there any reason you cannot fully perform all duties that your employment work will require on any shift | ☐ Yes ☐ No | |
| Have you ever had a work related injury or Illness | ☐ Yes ☐ No | |
| Have you ever been off work more than one day due to a job related illness or injury | ☐ Yes ☐ No | |
| Do you have a history of chronic back problems? | ☐ Yes ☐ No | |
| Have you ever had loss of strength or function in your, (Hand, Feet Hip, Wrists, Ankles, Back, Arms, Knees, Neck, Legs) | ☐ Yes ☐ No | |
| Are you able to fulfill the duties of a caregiver including Assisting patients in transferring from a Bed to a Commode safely greater than 50 lbs. | ☐ Yes ☐ No | If no, Please explain |

Have your been vaccinated for Covid-19 ☐ Yes ☐ No if so When? _____

Free of communicable diseases? ☐ Yes ☐ No *(if no, list specific precautions to prevent the spread of disease to others)*

HEP B Vaccine: Date Accepted or Declined: Accepted Date: _____ Declined Date: _____

**Limitations or Restrictions for Activities** *(including work day, lifting, standing, and bending picking up items greater than 50 lbs)* ☐ No ☐ Yes

*(specify):* _____

**Have you had any Surgery's that would limit or prevent you from fulfilling the Job duties of a Caregiver** ☐ Yes ☐ No

**If yes please explain:** _____

If yes please list the Date when you are able to return to work at Full duty: _____

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Are you able to fulfill your job description without any accommodation ☐ Yes ☐ No
If no please explain: _____

**Explanation and Instruction:** Our company policy requires all employees who have direct contact with patients in the home setting to submit a statement from an appropriately licensed health care professional, based on an exam performed within the last twelve months. The employee must show no apparent signs or symptoms of communicable disease.

**Statement to be signed by a Physician or appropriately licensed Healthcare professional.**

_____was examined by me on _____. He/She is in adequate health to perform home health duties and show no apparent signs or symptoms of communicable disease.

Professional Address:

| | | |
|---|---|---|
| Address: | | City |
| State: | Zip: | Phone: |

_____ _____ _____
Professional Printed Name Professional Signature Date

**2 Step PPD**

**Step 1:** Rt. Forearm_____ Lt. Forearm_____, A PPD test done in the office on _____ by _____ and read on _____ by _____ Results: _____ if redness present: size/description _____
Manufacturer name _____ Lot Number_____

**Step 2:** Rt. Forearm_____ Lt. Forearm_____, A PPD test done in the office on _____ by _____ and read on _____ by _____ Results: _____ if redness present: size/description _____
Manufacturer name _____ Lot Number_____

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**A Quantiferon Gold TB Test: Results**: Positive_____ or Negative_____ (Please attach Results)
**A Chest X-Ray Results**: Positive_____ or Negative_____. (Please attach Results)

**Rubella and Rubeola immune with Titers or MMR Vaccine** **(New Jersey Applicants ONLY) (*Please Attach Results*)**

Rubeola Screening (born in 1957 or later): Employee DOB: _____ Date_____
Rubella Screening Date: _____

_____ _____ _____
Professional Printed Name Professional Signature Date

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I (Caregiver/Applicant Full Name) _____ understands that if any of the information that is listed in this physical changes in any way that would limit or prevent me (caregiver/applicant) from fulfilling the Job duties of a Caregiver, it is my (caregiver/applicant) responsibility to inform the office before the next scheduled work shift. I understand that if I fail to notify the office, I (caregiver/applicant) can potentially put infinity Healthcare services client's and or co-works in harm's way because of my (caregiver/applicant) actions of not being able to fully fulfill the Job duties of a Caregiver limitation that was not disclosed to the infinity healthcare Services. This act can lead to disciplinary actions including termination.

_____ _____ _____
Caregiver/Applicant Name Caregiver/Applicant Signature Date