



Email: info@jodalhealthcare.com

STAFF MEDICAL

GENERAL INFORMATION

(To be completed by employee)

NAME: _____

ADDRESS: _____

PHONE No.: _____ SEX: _____ D.O.B. _____

PHYSICAL EXAMINATION

(To be completed by a licensed physician)

This individual has been hired for a position with JODAL HEALTH CARE, INC., which will entail working with seniors, developmentally, physically, and mentally challenged individuals. In the course of your examination, please note any medical problems of which we should be aware.

GENERAL ASSESSMENT:

Is the individual physically fit for his/her duties that may require physical exertion?

	<u>Yes</u>	<u>No</u>
Cardiovascular	()	()
Musculoskeletal	()	()
Sensory (vision/hearing)	()	()
Other systems	()	()

Are there any conditions restricting the physical ability to work:

IMMUNIZATIONS:

Is this individual fully immunized?

() POLIO () TETANUS () MEASLES

www.jodalhealthcare.com

877 Wilson Avenue, Unit 12, North York, ON M3K1E6

Main Phone: 416-398-0078 Fax: 416-398-0094 After Hours: 416-899-6560



☐ MUMPS ☐ RUBELLA

DATE OF MOST RECENT BOOSTER:

ALLERGIES:

Is this individual allergic/sensitive to any of the following?

☐ PENICILLIN ☐ INSECT STINGS ☐ OTHER DRUGS
☐ FOODS ☐ ANIMALS ☐ OTHER

Specify:

This is to certify that I examined _____ and reviewed his/her laboratory test results. I have found him/her not a carrier of Hepatitis B, free from active tuberculosis, and free from other communicable and contagious disease. I believe he/she is fit to undertake his/her duties associated with his/her position with JODAL HEALTH CARE, INC.

DOCTOR'S SIGNATURE:

DATE:

PLEASE PRINT CLEARLY THE FOLLOWING INFORMATION:

DOCTOR'S NAME:

CLINIC ADDRESS:

PHONE No.: _____

