SECTION B

CONFIDENTIAL

PHYSICAL EXAMINATION RECORD TO BE COMPLETED BY EXAMINER

TEMPERATURE	BLOOD PRESSURE	PULSE	RESPIRATION
	R/Sys. Dia.	/MIN.	/MIN.

I. CHECK ONE BOX FOR EACH CATEGORY

WNL- WITHIN NORMAL LIMITS ABN- ABNORMAL ANY ABN MUST BE EXPLAINED AT THE BOTTOM OF PAGE

	WNL	ABN		WNL	ABN		WBL	ABN
1. HEAD- GENERAL			**9. ABDOMEN**			**12. Extremities**		
2. EYES			a. Hernia			Joints		
a. Eyeball			**10. UROGENITAL**			a. Shoulders		
b. Cornea			a. External (Male)			b. Elbows		
c. Pupil			Genitalia, Testes			c. Wrists		
d. Pupillary Reflex			**11. SPINE**			d. Hands		
3. EARS			I. Cervical			e. Hips		
a. Canals			a. Curvature			f. Calves		
b. Drums			b. Flexion			g. Shoulder Girdle		
4. NOSE			c. Extension			h. Pelvic Girdle		
5. MOUTH/THROAT			d. Rotation			i. Evidence of Prior Surgery		
6. NECK			II. Thoracic					
a. Lymph nodes			a. Curvature			**13. NEUROLOGICAL**		
b. Main Vessels			b. Flexion			a. Motor Function		
c. Thyroid Gland			c. Extension			b. Reflexes		
7. CARDIOVASCULAR			d. Rotation			c. Coordination		
a. Auscultation			III. Lumbar			**14. SKIN**		
8. THORAX/LUNGS			a. Curvature					
a. Expansion			b. Flexion					
b. Shape			c. Extension					
c. Auscultation			d. Rotation					
			IV. Evidence of Prior Surgery					

II. VISION

COLOR VISION	WITHOUT CORRECTIVE LENSES	WITH CORRECTIVE LENSES	PERIPHERAL VISUAL FIELD	DEPTH PERCEPTION
WNL_____	Distant R20/ L20/	Distant R20/ L20/	R_____	_____
ABN_____	Near R20/ L20/	Near R20/ L20/	L_____	

FURTHER TESTING REQUIRED

YES	YES
Audiometric Exam & Interpretation (audiogram must be attached)	Evaluation for fitness to wear a respirator (including evaluation of the spirometry test)
Blood Tests, Specify_____	Chest X-Ray (PA & Lateral
Jackson Evaluation	Med-X Back Evaluation (Baseline)
Spirometry Test	Other_____
DOT Exam and Certification	_____

RESPIRATOR EVALUATION

_____NO RESTRICTION ON RESPIRATOR USE. _____NO RESPIRATOR USE PERMITTED _____MEDICAL EVALUATION REQUIRED

USE THIS SECTION TO EXPLAIN ANY CATEGORIES CHECKED ABN AT TOP OF PAGE

_____

_____

_____

This individual:

☐ is medically qualified to perform the job described

☐ is medically qualified with the following restrictions and or medications: ☐ requires further medical evaluation

This individual has been informed of any medical findings and my recommendations.

EXAMINEE'S SIGNATURE	DATE	EXAMINERS SIGNATURE	DATE