Elderly Muslim Care Action Network, Inc.

1260 Iroquois Ave. Unit 108, Naperville IL 60563

Phone **(630) 701-7755** Fax **(630) 701-7766,** eMail **info@emcan.us** Web **www.emcan.us**

EMPLOYEE PHYSICAL EXAMINATION FORM

NAME:_____ **DATE:**_____

ADDRESS:_____ **TELEPHONE:** _____

I herby release the physician identified in this form to release the results of my physical examination to Elderly Muslim Care Action Network, Inc.

_____

Applicant's Signature

_____

SECTION B:

Dear Doctor: The following are the essential functions a **HOME CARE AIDE** performs: Taking care of persons with disabilities in their own homes. Providing personal care such as grooming, bathing and dressing to bed bound individuals. Performing household tasks such as dusting, vacuuming, sweeping, and mopping floors, meal preparation, shopping, and laundry. Involves lifting and transferring of clients bending and continuous carrying.

SECTION C:

To be completed by Physician

MEDICAL HISTORY:_____

_____

_____

GENERAL APPEARANCE:

_____

Height: _____ Weight: _____ B/P: _____ Pulse: _____ RP: _____

TESTS:	DATE	Result (Circle)
Mantoux Test	_____	+ ☐ or ☐ -
X – Ray (if positive reaction)	_____	_____

EXAMINATION:

Eyes: (R) ____ (L) ____ Does he / she uses or needs glasses? Yes☐No☐

Ears: (R) ____ (L) ____ Does he / she uses or needs a hearing aid? Yes☐No☐

Nose: _____ Throat: _____ Mouth: _____ Neck: _____

Thyroid: _____ Glands: _____ Skin: _____ Chest: _____

Breasts: _____ Heart: _____ Lungs: _____ Abdomen: _____

Genital: _____ Neurological: _____ Musculoskeletal: _____

(Please Complete Reverse Side)

EMCAN
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Please respond to each of the following questions and provide an explanation of your response as indicated:

1. Can he / she work an 8 hour day? Yes No ☐
   If not, please explain _____

2. Can he / she lift weight of 25 – 30 lbs, on a regular basis? Yes ☐ No ☐
   If not, please explain _____

3. Can he / she lift and transfer bed bound individuals? Yes ☐ No ☐
   If no, please explain _____

4. Does he / she have any chronic conditions which would prevent the performance of the essential functions of this job? Yes ☐ No ☐
   If yes, please explain _____

5. Is he / she under continuing medication? Yes ☐ No ☐
   If yes, please explain _____

6. Are there any effects of this medication which would prevent him / her from safely performing essential functions of this job? Yes ☐ No ☐
   If yes, please explain _____

7. Does he / she have any of the following allergies which would prevent performing essential functions of this job as specified in section B of this form or which should be considered in determining his / her work assignment?

Cigarette smoking:	YES ☐ NO ☐	
Dust:	YES ☐ NO ☐	
Animals:	YES ☐ NO ☐	If yes, please specify: _____
Cleaning supplies:	YES ☐ NO ☐	If yes, please specify: _____
Other allergies:	YES ☐ NO ☐	If yes, please specify: _____

8. Can he / she as a regular part of the job:

Stand most of the day?	YES ☐ NO ☐	Bend and reach?	YES ☐ NO ☐
Climbs stairs frequently?	YES ☐ NO ☐	Walk?	YES ☐ NO ☐
Operate household machinery and equipment? ☐			YES ☐ NO ☐
Use public transportation?	YES ☐ NO ☐		

If your answer to any of the above was NO, please explain _____
FINDING & RECOMMENDATIONS: _____

_____

_____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____
PHYSICIAN'S NAME (Please print) _____
FACILITY: _____
ADDRESS: _____
TELEPHONE: _____