

Cumberland County Board of Education

368 Fourth Street, Crossville, TN, 38555

Phone 931-484-6135 Fax 931-484-6425

EMPLOYEE PHYSICAL EXAMINATION FORM

TO BE COMPLETED BY EMPLOYEE:

Name Phone number

Address City State Zip code

TO BE COMPLETED BY PHYSICIAN: (Physical Examination must be performed by a licensed physician.)

DATE OF EXAMINATION: _____ GENERAL APPEARANCE: _____

HEIGHT: _____ WEIGHT: _____ ALLERGIES: _____

TEMPERATURE: _____ PULSE: _____ RESPIRATION: _____ B/P: _____

System	Normal		If No/Abnormal – Comments:
	Yes	No	
Skin			
Eyes			
Ears			
Nose			
Throat/Dental			
Cardiovascular			
Respiratory			
Gastro Intestinal			
Geniro Urinary			
Neurological			
Musculoskeletal			
Other			

Summary of Findings: _____

2) Urinalysis: Albumin _____ Sugar _____

3) Substance abuse urinalysis (Amphetamines, Cannabinoids, cocaine, Phencyclidine, Methamphetamine, and Opiates. Results need to be sent to the Cumberland County Board of Education Human Resources Office.

4) I hereby certify that I have examined the above applicant and that the above is a complete and accurate record of my examination.

5) I hereby state that this employee is in good physical and mental health which allows him/her to perform the essential functions of the position for which he/she is applying.

Teacher _____ Support Staff _____ Food Service _____ Transportation _____

PRINT PHYSICIANS NAME: _____

SIGNATURE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE #: _____ FAX #: _____

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NEW EMPLOYEE MEDICAL HISTORY

The following information is a requirement of the post-offer of employment medical examination. This section should be completed prior to the medical examination and be available to the examining physician.

1 Please list any conditions or diseases for which you have been treated in the past five years.

2 Have you ever been hospitalized? If so, when and for what Condition:

3 Is there any health-related reason you may not be able to perform the job for which you are applying?

4 Have you had a major illness in the last five years? If so, Describe.

5 How many days were you absent from work because of illness last year? _____

6 Do you have any physical defects which preclude you performing certain kinds of work?

7 Are you taking any prescribed medications? Yes _____ No _____

8 Have you ever filed for worker's compensation benefits? Yes _____ No _____

Year _____ Injury _____

I verify that the information provided is correct to the best of my knowledge. Further, I understand that misrepresentation of any of the above statements may subject me to loss of position if employed.

Employee Signature

Date