Healthcare
Progressive
Staffers

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Lithonia, GA 30058
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Annual Physical Form

Name: _____
First, Middle, Last

Current Address: _____

City: _____ State: _____ Zip:_____

Social Security # (last four only): _____

I hereby authorize to release my medical records to HPStaffers.

Signature: _____

Note: It is your responsibility to have your physician to fill out the appropriate section of this form.

TB/PPD: _____ (date) _____ (results) annual

T-SPOT: _____ (date) _____ (results) annual

MMR Vaccine/
Titer w/7yrs: _____ (date) _____ (results)

Hep-B Vaccine/
Titer Series w/7 yrs: _____ (date) _____ (results)

Varicella Vaccine/
Titer w/7 yrs: _____ (date) _____ (results)

Tdap Vaccine w/10 years: _____ (date) _____ (results)

I have examined the above individual and to the best of my knowledge he/she is in good physical and mental health with no restrictions.

_____

Physician or Nurse Manager Date