

AUM Nursing Care Center Medical Report

Name: Carlissa Brown	Date of Birth: 1/14/92
Address:	Position:

This examination is needed to determine my physical ability to perform the activities required for the above position. I hereby authorize the staff at the AUM-Nursing Care Center to furnish a report of my examination to:

Name of person or facility

Signature

Date

TESTS (to be completed if other verification is not attached):

Date and result of Intradermal Tuberculin Test (Mantoux): N/A

Date and result of chest x-ray if Mantoux was positive: _____

HISTORY of any chronic disease of disability that may affect his/her ability to perform services or activities in the required position: Yes _____ No ☒

PHYSICAL LIMITATIONS that may affect or limit his/her ability to perform activities for the above position: Yes _____ No ☒

If "Yes" to either of the above questions, please explain:

In my opinion, the physical examination reveals that the above-named person is free of any infectious or contagious disease and is physically fit. If not, please explain:

Melody M. Ha
Signature of certified nurse practitioner
Adopted 6/93

5/3/18
Date

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