COASTAL HEALTHCARE RESOURCES

Phone: 843-679-3251
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Po Box 6467
1807C West Evans Street
Florence, SC 29502

PHYSICAL STATEMENT

Professional's Name (Print):_____**Date:** _____

Professional's Signature: _____

Date of Birth: _____/_____/_____ **Social Security #:**_____

Date of Exam: _____/_____/_____ **(**expires one year from exam date)

Vital Signs: T_____ **P** _____ **R** _____ **BP** _____ **Height** _____ **Weight** _____

Tuberculosis Screening

1. Have you ever had a **POSITIVE** TB skin test? ☐ Yes ☐ No
2. Have you ever received BCG vaccine? ☐ Yes ☐ No
3. Do you have a history of Tuberculosis? ☐ Yes ☐ No

☐ **PPD Skin Test** Dose: _____ Lot #: _____ Expiration: _____
Date Administered: _____ Placed By: _____
Date Read: _____ Read By: _____
Results: ☐ Negative ☐ Positive Size of Induration: _____ mm
☐ **CXR (attach positive PPD)** Date of CXR: _____/_____/_____
(Include copies of all documentation for lab results/readings)

Physician's Statement:

I have performed a physical examination on the above individual and have found this person to be in good physical and mental health. The individual appears to also be free from any contagious diseases. He/she is able to perform all the job duties of the health care profession to full capacity without any limitations.

Provider's Name (Print): _____
(Physician, Certified Nurse Practitioner, or Physician Assistant)

Signature: _____ License #: _____

Address: _____ Phone: _____

_____ Fax: _____

Date: _____/_____/_____

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