ALLIED HEALTH
Physical Examination Form

1. Name: _____
2. Date of Birth: _____
3. Address: _____
4. Phone: (_____) - _____ - _____
5. **Step 1** PPD Test
   - o Date Administered : _____
   - o Date Read: _____
   - o Read by: _____
   - o RESULT: _____

OR

QuantiFERON TB Gold Test

Results _____

Date_____

Initials _____

NEW students only

Step 2 PPD Test (administered 7 days after first one is read)

- o Date Administered : _____
- o Date Read: _____
- o Read by: _____
- o RESULT: _____

6. Hepatitis B Vaccine #1_____ #2 _____ #3 _____

7. ADVANCED PRACTICE CLINICIAN/PHYSICIAN AFFIDAVIT ***(Must be completed)***
   I, as a licensed and registered CLINICIAN, under the laws of the Commonwealth of Pennsylvania, County of _____ have examined _____and find him/her to be **free of all infectious diseases** with the ability to lift, push, pull, and transfer **a minimum of 50 pounds**.

Provider's Signature
_____

Provider's Printed Name
_____

Provider's Registration Number
_____

Provider's Address
_____

Date: _____

Office Stamp