Physical Evaluation Report to be Submitted to Access Services

Host Family Provider Information *(to be completed by host family provider)*

Last Name:_____ First Name:_____ Date:_____

Address:_____ City:_____

State:_____ Zip:_____ Phone:_____

In case of emergency notify – Name:_____ Phone:_____

Personal physician – Name:_____Phone:_____

Address:

_____

Healthcare Provider Evaluation *(to be completed by physician)*

Clinical Impressions/Work Restrictions

- As far as can be determined from this examination, is the patient able to perform the duties as described? ☐ Yes ☐ No

- As far as can be determined from this examination, is the patient free and clear of all communicable diseases and/or medical problems which might interfere with the health, safety, or well-being of other individuals? ☐ Yes ☐ No

  If no, what precautions need to be taken or what other information is necessary to ensure the health/safety of other individuals?_____

- Date Physical Completed: _____

Signature of Physician, Certified Nurse Practitioner or Registered Physician's Assistant

Signature:_____ Date: _____

Print or Stamp Name, Address, City, State, Zip _____

Laboratory Work Ordered (as applicable):

Mantoux test location:_____ Mantoux test results: _____

Date applied: _____ Date read: _____

Please return this page fully completed, to:
Fax:
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