



# COTTAGE HOME CARE MI, LLC

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- Pre-Employment Physical Assessment    
  Annual Assessment    
  Return to work/LOA    
  Other:

<b>Name:</b>	Marital Status:    M    S    W    D	Sex:    M    F
<b>Address:</b>	<b>Social Security#</b>	<b>Title:</b>

### PHYSICAL EXAMINATION

HEAD/ENT:					
EYES:					
NECK:					
BREASTS:					
LUNGS:					
CARDIOVASCULAR:					
MUSCULOSKELETAL:					
ABDOMEN:					
GENITOURINARY:					
CENTRAL NERVOUS SYSTEM:					
COMMENTS					
<b>HT:</b>	<b>WT:</b>	<b>B/P:</b>	<b>PULSE:</b>	<b>RESP:</b>	<b>TEMP:</b>

### LABORATORY TEST RESULTS

TEST	DATE PERFORMED	RESULTS Provide lab values and interpretation		
RUBELLA TITER		NON-IMMUNE	IMMUNE	LAB VALUE:
MEASLES TITER		NON-IMMUNE	IMMUNE	LAB VALUE:
PPD (ANNUALLY) / QFT	1 DATE IMPLANTED	1 DATE READ		RESULTS (mm/mm):
	2 DATE IMPLANTED	2 DATE READ		RESULTS (mm/mm):
CHEST X-RAY (+PPD)	DATE:	RESULTS:		

### IMMUNIZATIONS:

IMMUNIZATIONS:	DATE	DATE	DATE
RUBELLA	1.		
RUBEOLA/MEASLES	1.	2.	
HEPATITIS B VACCINE	1.	2.	3.
DRUG SCREEN (8 PANEL)			

- This individual is free from any health impairment that is a potential risk to the patient or other employees or which may interfere with the performance of his/her duties including habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol or other substances that may alter behavior.
- This individual is able to work with the following limitations:
- This individual is not physically/mentally able to work (specify reason):

Physician's Signature: \_\_\_\_\_

Lic. # \_\_\_\_\_ Date: \_\_\_\_\_

**OFFICE STAMP:**