

**I AM UNIQUE  
SPECIAL CARE & CASE MANAGEMENT**

EMPLOYEE HEALTH EXAMINATION

Employee Name: \_\_\_\_\_ Class \_\_\_\_\_

Dear Dr. \_\_\_\_\_

The above individual who has arranged for you to do an employee health examination has been hired by I AM UNIQUE, SPECIAL CARE & CASE MANAGEMENT. Their position has the following requirements:

- visual/hearing ability sufficient to comprehend written/verbal communication
- ability to exercise common sense, patience, and tact
- adequate listening skills
- ability to think clearly and make logical decisions in emergency situations
- ability to deal effectively with high levels of stress
- ability to do extensive bending and lifting on a regular basis
- ability to participate in regular physical activity
- ability to work for extended periods of time while standing and being involved in physical activity

Please complete the following items, considering the above position requirements and the completed Medical History form attached for your reference.

1. Allergies \_\_\_\_\_

2. Past injuries \_\_\_\_\_

3. Past illnesses \_\_\_\_\_

4. Current injuries \_\_\_\_\_

5. Current illnesses \_\_\_\_\_

6. Blood pressure \_\_\_\_\_

7. Hearing \_\_\_\_\_

8. Vision \_\_\_\_\_

9. Heart \_\_\_\_\_

10. Back \_\_\_\_\_

11. Hernia \_\_\_\_\_

12. Urinalysis \_\_\_\_\_

13. Hemoglobin \_\_\_\_\_

14. Last TB/Chest X-Ray \_\_\_\_\_  
(must be done annually)                      Date                      Result

15. Other \_\_\_\_\_

16. Employee examination outcome (please check and complete one below)

\_\_\_\_\_ I have examined \_\_\_\_\_ and have not  
(employee name)  
found a condition at this time that appears to prevent this person from  
fulfilling the position requirements described above.

\_\_\_\_\_ I have examined \_\_\_\_\_ and have  
(employee name)  
found a condition at this time that appears to prevent this person from fulfilling the  
position requirements described above. (Please describe condition and  
recommendations below.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Physician Address

\_\_\_\_\_  
Physician Telephone Number