**Medical form to be completed by primary care provider prior to CNA Employment**

During employment as a CNA for Home Instead it may be necessary to do maneuvers such as lifting (25 lbs.), twisting, bending, kneeling, reaching, pushing, pulling, carrying, and being on one's feet for extended periods are all necessary body functions that are required on a daily/ frequent basis during assistance with ambulation, transfers, bathing, toileting, providing safety assurance and a safe atmosphere during care provision. Please indicate whether **(CNA Name)________________________** can physically perform the stated duties of the job position.

_______Able to perform duties as described

_______Unable to perform duties as described

Date of most recent physical exam______________________

**TB RESULTS**

TB test planted____________ Read______________ Result____________

X-ray____________ QuantiFERON Gold Test_______________

**VACCINATIONS/ TITERS**

Tdap (within 10 years)______________

MMR (2) ________________ /_______________ Or MMR Titer________________

Varicella (2) _____________ /_______________ Or Varicella Titer ______________

Covid vaccines______________/ _______________/ ______________ /___________

Mfg._________________/ __________________ / ____________________ /______________

Most current Influenza Vaccine ________________________

Hepatitis B Vaccines _____________ / ________________ / __________________

Physician printed name________________________________

Physician Signature__________________________________ Date signed ________________________

Physician phone #______________________

HR Representative______________________ Date_______________

# Physical Exam & Immunization Requirements

**Student's Name**

| Last | M/I | First | Sex | DOB (DD/MM/YYYY) |
|---|---|---|---|---|
| | | | | / / |

## Tests:

**(Please attach proof of results. Must be no more than 1 year old. If the results are positive, a chest x-ray is required)**

| **TB Skin Test** ☐ Pos ☐ Neg | Date Planted | Date Read | **TB Chest X-ray** ☐ Pos ☐ Neg | Date Read |
|---|---|---|---|---|
| | | | | |

## Immunizations (Give most recent to date)

**(Please attach proof of records.)**

| Tdap (w/in last 10 yrs) | MMR (2 shots) or Titer with results attached | Varicella (2 shots) or Titer with results attached | Hepatitis B (3 shots) ***Optional*** |
|---|---|---|---|
| | | | 1.____________________<br>2.____________________<br>3. ____________________ |
| Influenza (current year): | | | |

## Physical Exam

This form is to certify that ____________________________________ has had a physical within the past twelve months, is physically able to perform the duties of a Certified Nursing Assistant (see attached job description) and free from communicable diseases.

Name of Physician: ____________________________________________

Address: ____________________________________________________

Phone: (_______)___________________________

Date of Annual Physical: _____/_____/________

Signature of Physician: _______________________________________ Date: _____/_____/________