UNIVERSITY OF FLORIDA POST-OFFER PHYSICAL EXAM

POSITION #_____

NAME: _____ UF ID: _____ JOB TITLE: _____

HEIGHT: _____ WEIGHT: _____ T: _____ PULSE: _____ RESP: _____ O2 Sat%:_____

BLOOD PRESSURE: #1:_____/_____#2_____/_____#3:_____/_____ Other: _____

Far VISION: **Uncorrected / Corrected (circle one):** Right Eye: 20/_____ Left Eye: 20/_____ Both: 20/_____

☐ AC ☐ Asbestos ☐ BBP ☐ Diving ☐ Generic ☐ Hearing ☐ Pesticides ☐ Police ☐ Respirator ☐ Patient Contact ☐ Other

OBJECTIVE FINDINGS:

General Appearance	NL___ ABNL___	Neuro	NL___ ABNL___
Skin/Scars	NL___ ABNL___	Neck	NL___ ABNL___
EENT	NL___ ABNL___	Upper Extremities	NL___ ABNL___
Thyroid	NL___ ABNL___	Back	NL___ ABNL___
Respiratory	NL___ ABNL___	Lower Extremities	NL___ ABNL___
Heart/Vessels	NL___ ABNL___	Abdomen/Hernia	NL___ ABNL___

PROVIDER COMMENTS:

_____

_____

_____

_____

IMMUNIZATIONS:

Tdap: _____ MMR: #1 _____ #2_____ Varicella: #1_____ #2_____

Hep B: #1_____ #2_____ #3_____ Rabies: #1_____ #2_____ #3_____

Other: _____

OTHER TESTS:

TST: _____ T-Spot: _____ Varicella Titer: _____ PFT: _____ CXR: _____

CBC: _____ UA: _____ CMP: _____ EKG: _____

Audiometry: _____ Cholinesterase: #1_____ #2_____ Other: _____

RECOMMENDATIONS:

☐ Fit For Duty

☐ Fit For Duty **with** Restrictions: _____

☐ Not Fit For Duty: _____

☐ Clearance on Hold Pending Further Medical Information: _____

By signing below, I agree that I have been advised of the results of the medical examination I have just undergone. I understand that should I have medical limitations specific to the job I have been offered, I must advise my employer of such limitations PRIOR to starting work.

_____ _____
Employee Signature Date

_____ _____ _____
Medical Provider Printed Name Medical Provider Signature Date