

**ST. LEONARD'S COMMUNITY SERVICES**

**Function:** Human Resources  
**Policy:** Appendix 4 – Medical Examination Form  
**CMHO Standard(s):**  
**Approved:** January 2009

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**Appendix 4 MEDICAL EXAMINATION FORM**

**Approved January 2009**

(To be completed by the attending physician)

Patient Name:

Address:

Department:

Position:

Job Duties:

Doctor's Name:

Address:

Date Physical Completed:

**PHYSICIAN'S STATEMENT**

As a result of my examination of this patient, it appears that he/she is capable of performing his/her job duties as outlined in the attached job description, except as set out in my comments below. This patient does not have any communicable or contagious disease that will affect his/her co-workers or clients or his/her job performance.

Comments:

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Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**Immunization Record**

Tetanus \_\_\_\_\_ Date received Given by

Diphtheria \_\_\_\_\_ Date received Given by

Measles, Mumps, Rubella \_\_\_\_\_ Date received Given by

See copy of Immunization Record attached