한울 종합 복지관
Hanul Family Alliance

Chicago Office: 5008 N. Kedzie Ave. Chicago, IL 60625
Tel: (773) 478-8851, Fax: (773) 478-8552
Suburban Office: 1166 S. Elmhurst Rd. Mt. Prospect, IL 60056
Tel: (847) 439-5195 Fax: (847) 439-5197
Lake County Office: 333 E. IL Rte 83 B-6, Mundelein, IL 60060
Tel: (847) 393-7488 F: (847) 393-7517

www.hanulusa.org, e-mail: hanul@hanulusa.org

PHYSICAL EXAMINATION FORM

Name of Applicant: _____ Date: _____

Address: _____ Date of Birth: _____
Street

_____ (_____)_____
City State Zip Telephone

TO BE COMPLETED BY PHYSICIAN:

PHYSICIAN'S NAME: _____

ADDRESS: _____

_____

BLOOD

HEIGHT: _____ PRESSURE: _____

*** T.B. SKIN TEST**

WEIGHT:_____ RESULT: _____

Does the applicant have any medical problems which will prevent employment as a HOME CARE AIDE (who takes care of senior citizens and handicapped clients tasks, such as meal planning and meal preparation)?

Communicable Disease: YES [ ] NO [ ]

IF YES, PLEASE EXPLAIN: _____

_____

_____

_____

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MEDICAL CHECK LIST

Your response to the following questions will ensure the safety of the employee in case of an emergency and allow for reasonable accommodations that will assist in the hiring decision.

CAN THIS APPLICANT;	**YES**	**NO**
A. Work a full 8-hour day?	_____	_____
B. Work a half day?	_____	_____
C. 1. Can this person lift weights of at least 25~50LBS on a regular basis?	_____	_____
2. Can he/she list weights of higher increment in occasional basis?	_____	_____
(If no, please specify reason) _____		
D. Stand all day on the job?	_____	_____
E. Stand part of the day?	_____	_____
F. Bend as regular part of job?	_____	_____
G. Walk during most of the work day?	_____	_____
H. Climb stairs frequently?	_____	_____
I. Operate moving machinery for normal household duties?	_____	_____
J. Use public transportation regularly?	_____	_____
K. Any known allergies? (If yes, please specify)	_____	_____
_____	_____	_____
L. Are there any other working conditions of situations to be avoided?	_____	_____
M. Any chronic illnesses? (If yes, please specify)	_____	_____
_____		
N. Has applicant ever been treated for back problems, which would affect her/his abilities to perform her/his responsibilities on the position of Home care aide?	_____	_____
(If yes, please specify) _____		
O. 1. Is applicant under continuing medication?	_____	_____
2. For safety reasons, are there any effects to the medication that would prevent the applicant from carrying out the responsibilities?	_____	_____
(If yes, please explain) _____		
P. Other comments: _____		

SIGNATURE OF PHYSICIAN: _____ DATE: _____

This will authorize you to release the information to HFA concerning my record.

Signature of Applicant: _____