



# CERTIFICATE OF GOOD PHYSICAL AND MENTAL HEALTH

## PHYSICAL EXAMINATION

This certifies that \_\_\_\_\_  
Print Name

was given a physical examination on : \_\_\_\_\_  
Date

I find the above named person in good physical and mental health and with no apparent signs or symptoms that would limit the performance of routine job duties nor any communicable disease that could endanger residents.

\_\_\_\_\_  
Medical Physician's Signature Date

Print Doctor's Name: \_\_\_\_\_

Print Address: \_\_\_\_\_

City/State: \_\_\_\_\_

License #: \_\_\_\_\_

## PPD TEST

PPD Test Date: \_\_\_\_\_ Site: \_\_\_\_\_

Results - mm: \_\_\_\_\_

Chest Xray Yes \_\_\_\_\_ No \_\_\_\_\_ Results: \_\_\_\_\_

Comments and/or Treatments: \_\_\_\_\_

\_\_\_\_\_  
Nurse or Physician's Signature Date