FRONTIER HEALTH CARE SERVICES

FHC

PHYSICAL REQUIREMENT FORM
(Please Print Clearly)

The Ohio Department of Health requires you to have a basic Physical Exam. Please have the top box of this form signed by your physician. All physicals must be within 1 year of the start of the program. Physicals older than 1 year will have to be repeated.

Physical Exam

I have examined (name) ______________________________________ on (date) ____________ and have determined that he/she is able to perform the duties of a Nurse Aide with no limitations.

_________________________________   ___________________________________

Physician's Signature   Printed

Mantoux Tuberculosis (TB) Test

	1st Step- (read in 48-72 hours)	**2nd Step- (read 7-14 days after 1st step)**
Date Given:	____________________________	______________________________
Given By:	____________________________	______________________________
Site:	____________________________	______________________________
Date Read:	____________________________	______________________________
Read By:	____________________________	______________________________
Results:	____________________________	______________________________

If not read within these timeframes, injections must be re-started.

If history of positive TB results,
give chest X-Ray results: ____ Pos ____Neg ______________________________

Physician Signature

If a person shows positive for TB, they must be on medication and have a signed release from their doctor to participate in the Nurse Aide Training Program (STNA) classes.

Pre-Class Health Statement

I certify that I am free of any physical limitations, pregnancy limitations, or any other ailments that could prevent me from performing my duties in a satisfactory manner. I release Frontier Healthcare Services, LLC from any liability when enrolled in the Nurse Aide Training Program (STNA) classes.

___________________________________   __________________________________

Student's Signature   Date