STARPOINT
EMPLOYEE HEALTH EXAMINATION FORM

Employee's Name:________________________________ Date of Birth:__________________

Address:____ Phone #:______________________

PHYSICAL EXAMINATION:

Ears_________________________________ Heart_______________________________

Eyes_________________________________ Lungs_______________________________

Teeth________________________________ Blood Pressure_______________________

Nose/Throat___________________________ Reflexes_____________________________

Neck_________________________________ Back_______________________________

Additional history or information:

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Physician's recommended date employee to return for next physical exam:_________________

I have examined the above named individual and found them free from any communicable diseases.

______________________________________ ______________________________________
Signature of Examining Physician Date of Examination

09/11:cls