BAYSHORE JOINTURE COMMISSION
Personnel Department
900 Hope Road
Tinton Falls, New Jersey 07712

NEW EMPLOYEE HEALTH ASSESSMENT

Name_____ Date of Birth_____

Address_____ Telephone_____

Position_____ Building_____

Gender: ____M ____F Vision_____ Wears Glasses: Yes ( ) No ( )

Private Physician_____ Telephone _____

HEALTH HISTORY (Please specify approximate age at onset and duration):

Allergies_____ Headaches (severe or migraine)_____
Arthritis_____ Heart Disease_____
Asthma _____ Hernia_____
Convulsive Disorders_____ High Blood Pressure_____
Diabetes_____ Hepatitis_____
Digestive Disorders_____ Kidney Disease_____
Drug Sensitivities_____ Neuromuscular Disorders_____
Ear Problems_____ Orthopedic Problems_____
Eye Problems_____ Psychological Disorders_____
Fainting Spells_____ Respiratory Problems_____
Rheumatic Fever_____
Operations or Serious Injuries_____
List any other significant health problems_____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I AM PHYSICALLY/MENTALLY ABLE TO PERFORM ALL THE DUTIES OF MY JOB DESCRIPTION.

Date_____ Signature of Employee_____

PHYSICAL EXAMINATION

Height _____ Weight _____ Blood Pressure_____ Pulse_____ Respiration_____
Ears (Otoscopic)_____ Hernia_____
Eyes_____ Genito-Urinary_____
Lymph Glands_____ Orthopedic:
Thyroid_____ Structural_____
Nose_____ Posture_____
Throat_____ Feet_____
Teeth-Mouth_____ Skin_____
Heart_____ Nutrition_____
Lungs_____ Nervous System_____
Abdomen_____ Hearing_____

General Health: (Circle One) GOOD FAIR POOR

I certify that this person is physically (Circle One): ABLE UNABLE to perform all the duties required by his/her job description.

Date _____ Signature of Physician_____

COMPLETED FORM TO BE RETURNED TO PERSONNEL DEPARTMENT AT ABOVE ADDRESS.

BAYSHORE JOINTURE COMMISSION
900 HOPE ROAD
TINTON FALLS, N.J. 07712

TUBERCULOSIS TESTING AFFIDAVIT

I do hereby state and declare that I was tested for tuberculosis on _____.

Name: _____

Address: _____

Phone: _____

Applicant's Signature: _____

_____
Physician's Address & Telephone Number

_____
Physician's Signature

Mantoux Test Administered: _____

Results: _____