

MEDICAL EXAMINATION VERIFICATION FORM

I certify that the following examinations have been completed for

Employee Name / OSN

- Basic physical with vision testing
- 12 Lead EKG with interpretation (If medically indicated)
- Comprehensive metabolic panel
- CBC with differential
- Lipid profile
- Hepatitis Titer
- Urinalysis with microscopic
- Audiometry
- Prostate specific antigen (Age appropriate or family history, male only)
- PPD (TB test) – (Consent form required)
- Chest X-Ray (If medically indicated)

Physician, Certified Advanced Registered
Nurse Practitioner or Physician Assistant's
Signature

Printed Name

Examination Date

Physician, Certified Advanced Registered
Nurse Practitioner or Physician Assistant's
License Number