ASSURED NURSING
18725 N. Union St.
Westfield, IN 46074
Office: 317-862-8141
Fax: 317-862-8143

Health Assessment Form

Date	Employees Name	DOB	Phone

Full Address	Email

Each applicant must have a history and physical performed prior to consideration or appointment as part of the credentialing and privileging process. It is assumed that the applicant's examining practitioner will directly review the health information with the applicant. The examination shall be of sufficient scope to ensure that no person shall assume his/her duties unless he/she is free from health impairment which is a potential risk to the patient or which might interfere with the performance of his/her duties.

To Be Completed by the Applicant

Medical History: ____ /____ /_____

Medical: _____

_____

_____

Surgical: _____

_____

_____

Review of Systems: _____

_____

_____

Allergies (including latex): _____

_____

_____

Medications: _____

_____

_____

Habits (includes addiction to depressants, stimulants narcotics, alcohol or other drugs or substances which may alter the individuals behavior):

_____

_____

_____

To Be Completed by the Examining Practitioner

Physical Examination Date: ____/____/____

Weight: _____ Height: _____

Blood Pressure: _____ Pulse: _____

Temperature: _____

Vision Corrected: _____ Uncorrected: _____

Lymph Glands: _____

Ears, Throat & Hearing: _____

Chest/Lungs: _____

Heart: _____

Abdomen: _____

Back and Extremities: _____

_____

Health Issues that may be a risk to Patients or Practitioner:

_____

_____

_____

Other: _____

_____

_____

_____

Examining Practitioner's Statement: I have obtained an interim history, discussed a review of systems, and performed a physical examination on the above named practitioner. To the best of my knowledge, the above named is in good physical and mental health and is free from a health impairment, including a substance abuse problem, which is of potential risk to patients or which might interfere with the performance of the practitioner's duties, and the provision of quality patient care at each facility.

Examining Practitioner's Signature_____ Date ____ /____ /_____

Examining Practitioner's Printed Name _____

Examining Practitioner's Medical License # _____

Address _____

Phone (____) _____ Fax (____) _____ Email _____