HMI
HEALTH MANAGEMENT, INC.

EMPLOYEE HEALTH CERTIFICATE

Name: _____ Sex (**Please circle one):** ☐ Male ☐ Female

Date of Birth: _____ Telephone #: _____

Address: _____

Street City State Zip Code

I have examined the above-named person and certify that he/she is:

1. Free from communicable disease. Please Circle One: Yes No

2. In addition to a general physical health examination, the following tests have been done:

   Tuberculin test (check one): ☐ Tine ☐ PPD

   Date Placed: _____ Results/Date Read: _____

   Chest X-Ray, Date: _____ Result: _____

Please indicate if you are having any of the following problems for three to four weeks or longer:

1. Chronic Cough (greater than 3 weeks)	☐ Yes	☐ No
2. Production of Sputum	☐ Yes	☐ No
3. Blood-Streaked sputum	☐ Yes	☐ No
4. Unexplained Weight Loss	☐ Yes	☐ No
5. Fever	☐ Yes	☐ No
6. Fatigue/Tiredness	☐ Yes	☐ No
7. Night Sweats	☐ Yes	☐ No
8. Shortness of Breath	☐ Yes	☐ No

Remarks: _____

_____

_____

_____ _____

Signature of Examining Physician Date of Examination

_____

Printed Name of Examining Physician

Physician's Office: please place stamp or print address and phone number below

Revised 3/2019