

Appendix 2

Physician's Report

Name of Candidate: _____
Date of Physical Exam: _____
Examining Physician: _____
Address: _____
Telephone: _____

PLEASE ELABORATE BELOW ON POSITIVE FINDINGS

Height: _____ Weight: _____ B/P: _____ Pulse: _____
General Nutrition: _____
Skin: _____
Eyes: _____
Ears: _____
Nose & Throat: _____
Teeth & Gingiva: _____
Glands: _____
Heart: _____
Lungs: _____
Abdomen: _____
Genitalia: _____
Rectal: _____
Neuro-Muscular System: _____
Skeletal (posture): _____
Vision: R20/____ L20/____ Wears corrective lenses? Yes: No:

REQUIRED LAB WORK

CBC _____
Urinalysis _____
Albumen _____
Sugar _____
PPD (if not done within past year) _____
SMA-12 _____
Electrolytes _____
HIV Titer _____
VDRL _____

Is the candidate under treatment?

Yes: No:

If yes, please detail: _____

Should this candidate have restrictions on physical exercise? Yes: No:

If yes, please detail: _____

Please give any other important information relating to this candidate's physical health:

Date: _____ **Signature:** _____