
New Employee Medical Form

Personal Information

- Full Name: _____
- Date of Birth: _____
- Employee ID: _____
- Phone Number: _____
- Email Address: _____

Health Insurance Information

- Health Insurance Provider: _____
- Policy Number: _____
- Primary Care Physician Name: _____
- Emergency Contact: _____
- Contact Number: _____

Medical History

- Do you have any chronic medical conditions? Yes No

If yes, please specify:

- Are you currently taking any medications? Yes No

If yes, please list them:

- Do you have any allergies? Yes No

If yes, please specify:

- **Have you had any surgeries in the past?** Yes No

If yes, please specify:

- **Do you have any physical limitations or disabilities that the company should be aware of?** Yes No

If yes, please specify:

Immunization Records

- **Tetanus (Date of Last Shot):** _____
- **Hepatitis B:** Yes No Not Sure
- **COVID-19 Vaccination:** Yes No Not Sure
- **Influenza (Annual Flu Vaccine):** Yes No Not Sure

Medical Exam (if applicable)

- **Medical Exam Completed (Date):**

- **Doctor's Name and Contact Information:**

Fitness for Duty Certification

- **Based on the medical information provided, is the employee fit for the duties required in their job?**
 Yes No Pending Further Evaluation

Employee Acknowledgment

I hereby declare that the information provided is accurate to the best of my knowledge. I understand that false statements may lead to the termination of employment.

- **Employee Signature:** _____
- **Date:** _____

- **Doctor's Signature (if applicable):**

- **Date:** _____