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# 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:

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

If yes, please specify:

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### 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:** \_\_\_\_\_