

Your Home away from Home—Isaiah 32:18



Assisted Living  
Personal Care Home

129 South Railroad Avenue  
POB 411  
Mt. Vernon, GA 30445

Phone: 912-583-2020  
Fax: 912-583-2040

**Pre –Employment Physical**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Current Diagnosis: \_\_\_\_\_

Physical Limitations: \_\_\_\_\_

Mental Limitations: \_\_\_\_\_

Treatment: \_\_\_\_\_

I affirm that this individual does not have any conditions that would preclude her from performing the job duties required for personal care assisting. I affirm that at the time of this physical this individual does not pose a danger to him/herself or others.

Physician signature: \_\_\_\_\_  
*(required)*

Ga. License: \_\_\_\_\_  
*(required)*

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**TB SKIN TEST:**

*May be Completed at the local Health Department*

Date screened: \_\_\_\_\_

Result: \_\_\_\_\_

Patient is unable to have TB skin test due to : \_\_\_\_\_

Nurse: \_\_\_\_\_

Ga. License: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_