

**\*\*\* MUST BE COMPLETED WITHIN 30 DAYS FROM DATE OF HIRE & ANNUALLY THEREAFTER\*\*\***

**\*\* TAKE THIS FORM WITH YOU TO YOUR DOCTOR'S OFFICE \*\***

**ARIZONA'S CHILDREN ASSOCIATION  
PHYSICIAN'S REPORT**

**Employee: check whichever is applicable and complete personal information.**

- I provide direct services to children and families. (Requires performing physical restraint on children, ages up to 18, if necessary.)
- I provide support services. (Requires lifting of 30 lbs. or more.)
- I provide office/managerial work only.

**I AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION TO MY EMPLOYER**

_____ Employee Signature		_____ Employee Printed Name		
_____ Street Address		_____ City	_____ State	_____ Zip Code
_____ Today's Date	_____ Date of Birth	Sex: <input type="checkbox"/> Male	<input type="checkbox"/> Female	

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**NOTE TO EXAMINING PHYSICIAN:**

Under the State of Arizona's Department of Health Services licensure requirements for behavioral health facilities, the Arizona's Children Association must document in each employee's personnel file a physical examination which demonstrates that the employee's medical status does not conflict with their primary job duties.

To meet that state licensing requirement, we ask you to complete the following general physician's report AS IT RELATES TO THEIR DUTIES WHILE WORKING WITH OR NEAR EMOTIONALLY AND BEHAVIORALLY TROUBLED CHILDREN AND THEIR FAMILIES.

1. State of general physical health:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
2. Are there any medical problems that indicate to you that this person may not be qualified to perform their duties providing services to or working around behaviorally and/or emotionally troubled children and their families?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

_____ Examining Physician's Signature	_____ Type or Print Physician's Name
_____ Physician's Phone Number <small>Physical Form (Revised 4/17/00)</small>	_____ Date