

BASIC NURSING ASSISTANT MEDICAL FORM

Student note: The physical must be done **within the 30 days prior to the first day of class**. The TB test must have been completed **within the six (6) months prior to the first day of class**. **This form is due to your instructor on the first day of class**. Failure to complete and submit this form, as required, will result in being withdrawn from the Basic Nursing Assistant Certificate Program.

Name of Person Examined: _____

Birth Date: _____

I. TESTS (Two-step TB test, blood serum test*, or if positive, a chest x-ray report**)

Two-step TB test results:

Date Administered	Lot #	Date Read	Results	Signature
#1 _____	_____	_____	_____	_____
#2 _____	_____	_____	_____	_____

* Blood serum test results:

Provide evidence of a negative QuantiFERON Gold serum sample per guidelines recommended by the CDC

No active TB, see attached blood test results

** If positive, include a copy of a negative chest x-ray report

No active TB, see attached x-ray report

II. PHYSICAL ASSESSMENT

Basic Nurse Assistant (BNA) Training Program Physical Endurance Criteria

The BNA student is able to:

- Stand (e.g., at resident's side)
- Sustain repetitive movements (e.g., CPR)
- Maintain physical tolerance (e.g., work entire shift)
- Push and pull 25 pounds (e.g., position clients)
- Support 25 pounds of weight (e.g., ambulate resident)
- Lift 50 pounds (e.g., assist transfer client)
- Move heavy objects weighing from 11 to 25 pounds
- Use upper body strength (e.g., perform CPR)
- Squeeze with hands (e.g., operate fire extinguisher)

III. FINDINGS

Brief explanation of health problems or conditions, if any, that may affect the student's ability to perform the duties of a Nursing Assistant.

IV. RECOMMENDATIONS

The above individual was found free from symptoms of communicable disease, able to lift a minimum of 50 lbs. unassisted, and is otherwise physically and emotionally fit to perform the duties of a Nursing Assistant.

Yes No Needs assistance or accommodations

If "No" or "Needs assistance or accommodations," please explain: _____

Physician's Signature

Date

Physician's Address: _____

Physician's Phone: _____

