MATANUSKA-SUSITNA BOROUGH SCHOOL DISTRICT

Human Resources Department Ph: 907-746-9250 Fax: 907-761-4088 Physical Examination Form

Instructions to the Physician

1. Examine the Employee and conduct only those tests requested on the form. If your findings reveal the need for additional tests, document separately and submit an itemized bill with this voucher.

2. Maintain **Medical Examination** and **Medical History** forms in your patient file.

3. Return completed **Statement of Examining Physician** (on the reverse side of this form) to your patient for submittal to the Human Resources Department.

FOR MEDICAL EXAMINATION OF:

Date of Examination: Fee for Examination:

Physician's Name: Paid by Employee: ☐ Yes ☐ No

Physician's Street Address:

City / State / Zip:

Instructions to the Employee

1. State regulations require a physical exam upon initial employment and re-examination every three years thereafter.

2. This form must be submitted to the Human Resources Department along with the Statement of Examining Physician form. The fax number for the Human Resources Department is: (907) 761-4088.

3. Complete the following information.

Employee's Street Address:

City / State / Zip: Employee ID #:

REIMBURSEMENT INFORMATION - EMPLOYEES NOT COVERED BY DISTRICT HEALTH INSURANCE
Please see your collective bargaining agreement for specifics on reimbursement for physical examinations. Any employees seeking reimbursement shall first be required to submit said bill to any existing health insurer providing coverage to the employee. It shall be the responsibility of the employee to submit documentation of the actual cost of the examination to the District within the time frame specified in their respective collective bargaining agreement. Employees who qualify for reimbursement may submit a copy of their bill **and** a paid receipt to the **Human Resources Department.**

Employee's Signature: Date:

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OFFICE USE ONLY

Statement of Examining Physician

NOTE: Pursuant to Board Policy, 4 AAC 5, state statutes, and applicable collective bargaining agreements: This form must be submitted to the Human Resources Department within thirty (30) days of initial employment.

Employee ID #: _____ Position: _____

School / Department: _____

_____ was examined by me on _____
(name of employee) *(date)*

The examination included a review of his/her past medical history and thorough physical examination. A copy of the medical history and examination findings will be maintained in my patient file records. They may be reviewed by you or your authorized representative upon written request.

The employee was found to be free from communicable disease and to be physically and emotionally fit for his/her proposed duties. ☐ Yes ☐ No

If **No**, please list the reasons as to how/why the employee was found to be unfit for the position/duties assigned:

_____

_____

_____

_____

_____
Signature of Physician (MD, DO, PA, or NP)

_____
Printed Name of Physician