## Employee Medical Examination Findings California State University, Long Beach Home Address

| Recently you had a medical examination in our office. The results of this examination follow: |   |              |          |          |                        |  |
|---|---|--------------|----------|----------|------------------------|--|
| Medical History:  |   | Normal _     | Abnormal | ]        |                        |  |
| Physical examination  |   | n: Normal⊡   | Abnormal |          |                        |  |
| Audiogram:  |   | Normal□      | Abnormal | Abnormal |                        |  |
| Chest X-Ray: No active disease Normal Abnormal Not indicated                                  |   |              |          |          |                        |  |
| Breathing tests: Normal Abnormal  |   |              |          |          |                        |  |
| Laboratory tests:   |   | Normal       | Abnormal |          |                        |  |
| EKG:  |   | Normal _     | Abnormal |          |                        |  |
| Other   | comments:   |              |          |          |                        |  |
|   |   |              |          |          |                        |  |
|   | Your examination was normal.  |              |          |          |                        |  |
|   | The abnormalities noted above should be followed up with your personal physician. Copies of your medical record will be furnished upon your signed request.                               |              |          |          |                        |  |
|   | The abnormalities noted above have resulted in restrictions in your work duties or in your use of personal protective equipment as described in the accompanying Medical Evaluation Form. |              |          |          |                        |  |
|   | If you have any questions, please do not hesitate to call me.   |              |          |          |                        |  |
| Name of physician   |   |              |          |          |                        |  |
|   |   | Printed name |          |          | Signature of Physician |  |
| Addrace   |   |              |          |          | Date                   |  |