Office of the Diaconate
Diocese of Worcester

PHYSICAL EXAMINATION

Name: _____ Date of Birth _____

BP _____, P _____, T _____, R _____, HT _____ WT _____

Vision: Uncorrected _____ / _____ Corrected _____ / _____

General: _____

_____

Head and Neck: _____

Chest/Lungs: _____

Heart: _____

Abdomen: _____

Genitalia: _____

Ano-Rectal & Prostate: _____

Muscular-Skeletal: _____

Neurological: _____

Skin: _____

REQUIRED LABORATORY: CBC, URINALYSIS, FASTING CHEMISTRY 24, SEROLOGY, STOOL GUAIAC. TB TINE TEST, VARICELLA TITER, RUBELLA TITER, MEASLES TITER.

For patients over 35 years of age, CHEST X-RAY and EKG if indicated.

Note: The above required laboratory studies are in addition to any studies indicated by the History and Physical Examination

_____ _____
Signature of Physician Date

_____ _____
Physician's Name (Please Print or type)

_____
Address

_____
City State and Zip Code

Office of the Diaconate

OPHTHALMOLOGICAL EVALUATION

1. Uncorrected Vision — Right Eye _____ / _____
   Left Eye _____ / _____
2. Best Corrected Visual Acuity — Right Eye _____ / _____
   Left Eye _____ / _____

3. Is there any evidence of ocular disease that would be chronic, progressive, or require frequent treatment or surgery?

Yes _____ No _____

If yes, please explain. _____

_____

_____

4. Is there any limitations of vision that would preclude the applicant's performance of Ministry?

Yes _____ No _____

If yes, please explain. _____

_____

_____

_____

_____
Signature of Ophthalmologist

_____
Name of Ophthalmologist (Please print or type)

Please sign the following release:

I _____ grant permission to the Director of the Diaconate, Diocese of Worcester, Massachusetts to speak with my doctor regarding my medical condition, so any additional statements and interpretations of my medical condition might be ascertained as they pertain to my ability to undergo serious Diaconate Studies and Ministry.

_____ _____
Date Diaconate Applicant

_____
Witness