



MEDICAL FORM FOR TESTING FOOD HANDLERS

NAME:..... AGE:..... SEX:.....

ADDRESS OF  
EMPLOYEE.....

STOOL MICROSCOPY/CULTURE.....

WIDAL.....

SPUTUM- AFB.....

NASAL SWAB.....

RPR/VDRL.....

CHEST X-RAY.....

NAME OF DOCTOR.....

DOCTORS SIGNATURE.....

DATE .....

IN CARE OF.....