

EMPLOYEE HEALTH FORM

STATEMENT OF SATISFACTORY HEALTH (✓) IF THIS SECTION IS TO BE COMPLETED)

_____ is found to be in good health without evidence of communicable disease and free of work restrictions on this date. Date of last physical exam: _____

Date of 1st Mantoux: _____ Results: _____ MM Date: _____ Signature/Title: _____

Date of 2nd Mantoux: _____ Results: _____ MM Date: _____ Signature/Title: _____

(If Positive, need Chest X-Ray & Yearly ProMed TB questionnaire)

Date of Chest X-ray: _____ Results: _____

Repeat Chest X-ray required on ___/___/___ Other: _____

Repeat Chest X-ray with development of symptoms

Signed: _____ Date: _____

Physician or Licensed Nurse Practitioner or PA

EMPLOYEE HEALTH HISTORY (✓) IF THIS SECTION IS TO BE COMPLETED) DATE: _____

COMPLETED BY: SUPERVISING RN PHYSICIAN/LICENSED NURSE PRACTITIONER/PA

Yes No Yes No Yes No Yes No In last 12 months:

Diabetes Shortness of Breath Stroke Hospitalized

Heart Disease Asthma/Bronchitis Kidney Disease Lung disease

Tuberculosis Epilepsy/seizures Unexplained Fever Back/Spinal problems

Hepatitis B Mental Disorder Other _____

Do you have any of these conditions or any other conditions which might cause risk to the patient or could potentially interfere with the performance of one's duties, including the habituation of alcohol or current addiction to depressants, stimulates, narcotics, or other substances.

Do any of these conditions impair your ability to perform the essential functions of the job. If "yes" explain/give dates: _____

Disease	Had Disease			Dates (Month/Year)			Disease	Had Disease			Dates(Month/Year)		
	Yes	No	Year	Titer	Results	Vaccination		Yes	No	Year	Titer	Results	Vaccination
Chicken Pox							Mumps						
Measles (Rubeola)							G.Measles (Rubella)						

Employee Signature: _____ **Practitioner Signature/Title:** _____

EMPLOYEE HEALTH EXAMINATION RECORD (✓) IF THIS SECTION IS TO BE COMPLETED

Blood Pressure _____ T _____ P _____ R _____ Height: _____ Weight _____

Ears: _____ Abdomen: _____ Hernia: _____

Eyes: _____ GU History: _____ GI History: _____

Teeth: _____ Skin: _____ Extremities: _____

Nose & Throat _____ Scars: _____ Other: _____

Lungs: _____ Heart: _____

Major Illnesses/Operations/Injuries: _____

Work Restrictions Yes No If "yes," explain: _____

Physical accommodations required to perform essential functions of the job. If applicable explain: _____

May safely wear HEPA mask Yes No If "no," explain: _____

_____ is found to be in good health without evidence of communicable disease, is free from health impairment which may cause risk to the patient or which might interfere with his or her duty including the habituation of alcohol, addiction to depressants, stimulants, narcotic, or other drugs or substances which may alter your behavior.

Signed: _____ Date: _____

Physician or Licensed Nurse Practitioner or PA