



PHYSICIAN'S STATEMENT

NAME: _____ DATE: _____
FIRST MI LAST

A COMPLETED, SIGNED PHYSICIAN'S STATEMENT IS REQUIRED FOR EMPLOYMENT WITH AS NEEDED STAFFING. YOUR PRIMARY CARE PHYSICIAN MUST FILL OUT THE APPROPRIATE SECTION ON THIS FORM.

MEDICAL HISTORY:

- A. ARE YOU UNDER THE CARE OF A PHYSICIAN? YES NO
IF YES, REASON(S) _____
- B. ARE YOU TAKING MEDICATIONS? YES NO
IF YES, TYPE: _____
- C. ARE YOU WILLING TO HAVE BLOOD/URINE SCREENING FOR DRUGS/ALCOHOL AS A CONDITION OF EMPLOYMENT? YES NO
IF NO, EXPLAIN: _____

COMPLETE THE FOLLOWING AND ATTACH COPIES OF THE RESULTS.

TB SKIN TEST DATE: _____ RESULTS: _____
 CHEST X-RAY DATE: _____ RESULTS: _____
 (IF TB TEST IS POSITIVE)

NOTE: TB SKIN TEST MUST BE IN THE LAST YEAR. X-RAY WITHIN THE LAST TWO YEARS

IMMUNIZATIONS:

HEPATITIS B SERIES DATE: _____ DATE: _____ DATE: _____
 TETANUS BOOSTER DATE: _____
 MMR DATE: _____

TITERS:

MEASLES (RUBEOLA) DATE: _____ IMMUNITY PRESENT IMMUNITY NOT PRESENT
 MUMPS DATE: _____ IMMUNITY PRESENT IMMUNITY NOT PRESENT
 RUBELLA DATE: _____ IMMUNITY PRESENT IMMUNITY NOT PRESENT
 VARICELLA DATE: _____ IMMUNITY PRESENT IMMUNITY NOT PRESENT
 HEPATITIS B DATE: _____ IMMUNITY PRESENT IMMUNITY NOT PRESENT

I CERTIFY THAT THE ABOVE NAMED PERSON, TO THE BEST OF MY KNOWLEDGE, IS IN GOOD PHYSICAL AND MENTAL HEALTH, FREE FROM SYMPTOMS INDICATING THE PRESENCE OF AN INFECTIOUS DISEASE AND ANY CONDITION WHICH WOULD INTERFERE WITH THE PERFORMANCE OF HIS/HER DUTIES WHICH MAY REQUIRE: ASSISTANCE WITH TRANSFERS; SUPPORTING PATIENT DURING AMBULATION; PROVIDING PERSONAL CARE; AND SKILLED NURSING FUNCTION.

SIGNATURE OF PHYSICIAN DATE

PRINTED NAME OF PHYSICIAN

_____ I DECLINE THE HEPATITIS B VACCINE SERIES. I UNDERSTAND THAT BY DECLINING THIS VACCINE, I CONTINUE TO BE AT RISK OF ACQUIRING HEPATITIS B, A SERIOUS DISEASE.

DATE: _____ SIGNATURE: _____