Nursing Application

Phone: (845) 363-8140 Fax: (845) 363-8141

Application for Employment

FOR OFFICE TO COMPLETE:
Hire Date _____ Company_____

FOR APPLICANT TO COMPLETE:

Today's Date_____

Name: _____ Social Security #_____

NPI #: _____ Date of Birth: _____

Present address: Street: _____ Apt #_____

City: _____ State: _____ Zip Code: _____

Phone # _____ Cell# _____

Cell Phone Carrier _____ Email: _____

In case of Emergency Notify:

Name: _____ Phone: _____

Relationship: _____ Address: _____

☐ RN ☐ LPN Prof License # _____ exp. date _____State: _____

How did you hear about our agency? ☐ Indeed ☐ Walk in ☐ Recruiter ☐ Other: _____
Have you ever received compensation for injuries? Yes ☐ No ☐

Please ☑ if you have ever been disciplined or fired due to:

☐ Inadequate job performance ☐ insubordination ☐ violation of a safety rule ☐ fighting with or assaulting supervisors or colleagues ☐ Tardiness, absenteeism ☐ working under or possession of drugs or alcohol

If yes, please explain:_____

Position_____ Date you can start_____ Salary_____

Are you on layoff and subject to recall? ☐ Yes ☐ No Will you travel if required? ☐ Yes ☐ No

Will you relocate if job requires it? ☐ Yes ☐ No Will you work overtime if required? ☐ Yes ☐ No

Are you able to meet the attendance requirements of this position? ☐ Yes ☐ No

Driver's license number_____ State_____

Education	Name and location Of School	# of years Completed	Date Graduated?	Address
High school				
Business or Trade				
College				
Other:				

Summarize special skills and qualifications acquired from employment or other experiences that may qualify you to work with this company._____

_____

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EMPLOYMENT APPLICATION PAGE 2

List all previous Jobs you worked at: (List last employer first)

Date Month and Year	Name and address of employer	Salary	Job	Reason for Leaving
From				
To				
From				
To				
From				
To				

References: Give the names of three persons not related to you to whom you have known at least 1 year

Name	Address	Phone	Yrs acquainted

LICENSED PERSONNEL SKILLS:

☐	Trach care Venipuncture	☐	Cardiac care	☐	Enteral feedings	☐	
☐	Ileostomy care T.P.N	☐	Foley care	☐	Pediatrics	☐	
☐	Colostomy care Terminally Ill	☐	IV therapy	☐	Geriatrics	☐	
☐	Wound care _____	☐	O2 therapy	☐	Infants	☐	

CPR Certified: Yes ☐ No ☐ Exp. date___ _____

Awards, certifications, etc:_____

_____

Statement of Certification

I hereby certify, under penalty of immediate dismissal that this application for employment has been completed fully and correctly.
I understand that inquiries may be made to former employers or their agents, to personal references, and to others with whom I am or have been acquainted; and that those inquiries may include information regarding my character, my general reputation, my personal characteristics, and my overall working attitude. My permission is hereby granted to make such inquiries.
If I am accepted for employment with this agency, I agree to abide by its personnel policies and also to my supervisor any and all job related accidents and illness within twenty-four (24) hours of their occurrence, regardless of severity.

Signature: _____

Date: _____

Nursing Application

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EMPLOYEE NAME: _____

PRINT NAME

Drug Screening and Inspection Consent Form

DRUG FREE WORKPLACE

The Agency has a policy against drug and alcohol abuse and reserves the right to screen its employees as an enforcement measure in providing a safe, healthy, and productive working environment.

1.By my signature below, I am freely and voluntarily agreeing and consenting to submit a personal specimen of urine for chemical analysis and testing to determine the presence of any illegal, abused, or prohibited drugs/alcohol or substances in my body fluids, on a random basis as well as annual testing and for-cause testing. I understand that my refusal to submit a specimen of my urine for testing upon request will be grounds for my dismissal.

2.I hereby authorize the agency's duly appointed collection facility, and their personnel, to obtain, process, and test the specimen and to release and discuss the results of the analysis and test to the Director of Human Resources or designee for employment purposes. Said information will be handled as confidentially as is reasonably possible, shared only on a "need to know" basis.

3.I understand a documented chain of custody will be created to ensure the identity and integrity of my specimen throughout the collection and testing process.

4.As an employee, I understand if I have a positive test or refuse to submit to this drug/alcohol screening analysis and test, this will constitute a violation of the agency's policy and I will be subject to disciplinary action up to and including termination of employment. I understand that at the time of drug testing, I will be required to show copies of prescriptions for drugs prescribed and taken within the last thirty (30) days.

5.I hereby release, forever discharge, and hold harmless the agency , any physician, technician, medical facility and laboratory facility and all of their respective officers, directors, employees, representatives, and agents from any and all claims of whatever nature arising out of or in connection with any act or omission relating to any (1) examination, (2) test, (3) collection, (4) procedure, (5) chain of custody, (6) disclosure, (7) analysis, (8) diagnosis, (9) inaccuracy,(10) report, or (11) action performed. This release applies to any negligence, sole negligence, comparative negligence, concurrent negligence, gross negligence, recklessness, wantonness, willfulness, error, act, or omission of any of the individuals or entities covered hereby.

6.I understand and acknowledge that I will be required to allow the agency to search my person, personal effects, vehicle/ and other property located on agency premises or worksites, including agency vehicles and private vehicles located at the agency's premises or worksites. I also understand and acknowledge that my refusal to allow such searches to occur will be grounds for my immediate dismissal.

I HAVE READ AND UNDERSTAND THE ABOVE AND WILL COMPLY WITH THIS AGREEMENT.

_____ _____

Employee Signature ***Date***

Nursing Application

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CONFIDENTIALITY OF INFORMATION AGREEMENT

EMPLOYEE NAME: _____
PRINT NAME

Confidentiality of Information

- All information designated confidential that is obtained or generated as a result of any or all of the operations of the agency will be dealt with in a confidential manner.
- All information that is gathered maintained or stored by the agency becomes the agency's property and cannot be released without proper authorization from the administration.
- Altering information is prohibited by the agency and by law. Correction of any identified erroneous information must be done according to agency policy.

WHAT WE CAN DO TO MAINTAIN CONFIDENTIALITY OF INFORMATION

- In order to protect any individual from invasion of privacy and to protect the interest of the agency, any information gathered for patient care or operations will be gathered, maintained and stored in such a manner as to assure confidentiality.
- Access to information will be limited to a need to know basis to perform the scope of one's duties and responsibilities.
- Dissemination of information will be handled according to agency policy, and staff will be informed during orientation, will sign the confidentiality statement and it will be placed in the employee's file.
- Proven violation of breech of the confidentiality agreement may be cause for immediate termination.

I understand that I am responsible for following this Confidentiality Policy Agreement & The Guidelines, Both Written and Verbal.

_____ _____

Employee Signature ***Date***

Nursing Application

Phone: (845) 363-8140 Fax: (845) 363-8141

PERSONAL REFERENCE

Please provide the following information of one individual not related to you, to whom you have known at least one year

Name: _____

Phone: _____

Address: _____

City/Town: _____ **State:** _____ **Zip:** _____

APPLICANT NAME: _____

The above named applicant has applied for employment with our agency and requests/authorizes you to release all information below under the provisions of the Privacy Act of 1974. All information will be held in strict confidence.

_____ _____

Signature of Applicant **Date**

STOP – OFFICE USE ONLY

EVALUATION: Please check one for each statement

	YES	MOST OF THE TIME	SOME OF THE TIME	NO
Is this person dependable?				
Is this person trustworthy?				
Does this person follow instructions?				
Is this person cooperative?				
Does this person have a positive attitude toward others?				
Is this person able to cope with difficult situations?				

How long have you known this person? _____

Additional comments: _____

_____

Signature_____ **Date** _____

Verbally verified by _____ **Date**_____

RN/LPN APPLICATION

Phone: (845) 363-8140 Fax: (845) 363-8141

PROFESSIONAL REFERENCE

Name: _____

Agency/ Company Name: _____

Phone: _____ **Fax:** _____

Address: _____

City/Town: _____ **State:** _____ **Zip:** _____

The undersigned has applied for employment with our company and authorizes you to provide information concerning past performance under the provisions of the Privacy Act of 1974. All information is kept confidential.

APPLICANT NAME: _____ ***S.S.#*** _____

DATE: _____ **APPLICANT SIGNATURE:** _____

Please, do not complete anything below this line

==========

Please complete and sign

EMPLOYMENT DATES: From _____ To _____ POSITION: _____
Month/Yr. Month/YR.

REASON FOR LEAVING: _____

WOULD YOU REHIRE? ☐ YES ☐ NO

COMMENTS: _____

_____

_____

SIGNATURE: _____ **DATE:** _____

POSITION OR TITLE: _____ wkref

RN/LPN APPLICATION

Phone: (845) 363-8140 Fax: (845) 363-8141

PROFESSIONAL REFERENCE

Name: _____

Agency/ Company Name: _____

Phone: _____ **Fax:** _____

Address: _____

City/Town: _____ **State:** _____ **Zip:** _____

The undersigned has applied for employment with our company and authorizes you to provide information concerning past performance under the provisions of the Privacy Act of 1974. All information is kept confidential.

APPLICANT NAME: _____ ***S.S.#*** _____

DATE: _____ **APPLICANT SIGNATURE:** _____

Please, do not complete anything below this line

==========

Please complete and sign

EMPLOYMENT DATES: From _____ To _____ POSITION: _____
Month/Yr. Month/YR.

REASON FOR LEAVING: _____

WOULD YOU REHIRE? ☐ YES ☐ NO

COMMENTS: _____

_____

_____

SIGNATURE: _____ **DATE:** _____

POSITION OR TITLE: _____ wkref

Form W-4 (2019)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. ***Head of household please note:*** Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

---

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2019

1 Your first name and middle initial	Last name	**2 Your social security number**
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."	
City or town, state, and ZIP code	**4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2019, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►	**7**	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ► **Date** ►

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	**9** First date of employment	**10** Employer identification number (EIN)

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►**START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Permanent Residential Addresses

As per DOH regulations and in accordance with OCS statutes, please list **all** permanent residential addresses since birth, Including the month and year of residency.

1) _____
_____

2) _____
_____

3) _____
_____

4) _____
_____

5) _____
_____

MARQUIS
HOME CARE

230 N. Main Street, Spring Valley, NY 10977 Phone: (845) 363-8140 Fax: (845) 363-8141

Name: _____

DOB: _____

Date: _____

Referred By:

_____

$150.00 gift card given after employee works for 1 month

Declination of Influenza Vaccination for Health Care Personnel

Employee's Name: _____ Employee's ID#: _____

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider.

I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect this agency's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear.
- My shedding the virus can spread influenza to patients in this agency.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this agency, coworkers, my family and my community.

- **Because I have refused vaccination against influenza, I will be required to wear surgical or procedure masks in areas where patients may be present during the influenza season.**

I acknowledge that I have read this document in its entirety and fully understand it. Despite these facts, I have decided to decline the influenza vaccine by my signature below. I realize that I may re-address this issue at any time and accept vaccination in the future.

Signature: _____ Date: _____

HR Representative: _____ Date: _____

RN/LNP Application

Phone: (845) 363-8140 Fax: (845) 363-8141

Employee Name: _____

ANNUAL TUBERCULOSIS QUESTIONNAIRE

For personnel who have a known positive PPD or whole blood assay are required to complete this questionnaire with either a yes or no.

HAVE YOU NOTICED ANY OF THE FOLLOWING?

1. Unexplained fevers	☐ **Yes** ☐ **No**
2. Night Sweats	☐ **Yes** ☐ **No**
3. Unintentional weight loss	☐ **Yes** ☐ **No**
4. Cough	☐ **Yes** ☐ **No**
5. Hoarseness	☐ **Yes** ☐ **No**
6. Bloody Sputum	☐ **Yes** ☐ **No**
7. Have you completed INH therapy?	☐ **Yes** ☐ **No** If Y, Date of Completion :_____
8. Have you ever had a BCG vaccine?	☐ **Yes** ☐ **No**
9. Have you had an x-ray while employed here?	☐ **Yes** ☐ **No**

_____ _____

Employee Signature ***Date***

For Office Use:

Follow-up needed ☐ **Yes** ☐ **No**

Comments: _____

_____

_____

_____

Agency Representative: _____ ***Date***_____

RN/LPN Application

Phone: (845) 363-8140 Fax: (845) 363-8141

HEPATITIS INFORMATION ACKNOWLEDGEMENT
ACCEPT OR DECLINATION STATEMENT

I have read and understand the information in the Hep B Packet. My signature below indicates my acknowledgement of this information and my decision to either accept the Hep B Vaccination or decline the Hepatitis B Vaccination program.

Only choose **ONE** option:

DECLINE

☐ I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I **decline** Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

☐ I have received the Hepatitis B Vaccination series, and **decline** vaccination at this time.

ACCEPT

☐ I **accept** this opportunity to participate in the Hep B program, which includes a series of 3 injections at 0, 30, and 180 day intervals. I will comply with the administration procedure and am aware of adverse effects, contraindications, and complications that may occur due to the Hepatitis B Vaccination.

Employee Signature:_____ Date_____

Name (Print):_____

Agency Representative Signature_____ Date_____

RN/LPN Application

Phone: (845) 363-8140 Fax: (845) 363-8141

Medical Documents Required

In order for your medical file to be complete, the following information must be submitted:

1. Physical:
    - Clearance clause must include employee is cleared to work as well as the Habituation part.
    - Vitals must be completed
    - Must have doctors stamp/license number
    - Must be dated within the last six months
2. PPD results:
    - A skin test must be performed: the date PPD was placed, date read, results in millimeters and results read should be documented. PPD needs to be read within 2-3 days of being placed.
    - A Quantiferon can also be performed in place of a PPD (Lab report showing your results, if you are negative/positive)
    - ❖ If PPD is positive:
        1- You must submit a form with the date you became positive
        2- They need to submit a chest x-ray that is clear
3. Proof of immunity to Rubella and Rubeola (Measles). You can submit it as follows:
    a. Lab report showing the immunity, it should include the reference range
    b. 2 MMR shots done more than a month apart, you just need the dates of shots, immunity and signature

RN/LPN Application

Phone: (845) 363-8140 Fax: (845) 746-9930

EMPLOYEE'S PHYSICAL EXAM FORM TO BE COMPLETED BY PHYSICIAN

Dear Doctor: Please complete this form on the following person. This information is mandatory for employment in the health field.

NAME _____ DATE OF BIRTH _____ GENDER: _____

HISTORY

	YES	NO		YES	NO		YES	NO
Heart Disease	[ ]	[ ]	Hepatitis	[ ]	[ ]	Diabetes	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	Alcohol/Drug	[ ]	[ ]	Thyroid	[ ]	[ ]
Back Problems, Injuries	[ ]	[ ]	Anemia	[ ]	[ ]	Seizure Disorder	[ ]	[ ]
Arthritis	[ ]	[ ]	Asthma	[ ]	[ ]	Hernia	[ ]	[ ]
Emotional or Mental Problems	[ ]	[ ]	Cancer	[ ]	[ ]	Poor Hearing	[ ]	[ ]
Poor Vision	[ ]	[ ]	Tuberculosis	[ ]	[ ]	Allergies	[ ]	[ ]

If yes, please describe: _____

_____

Previous medical illness or surgical procedures: _____

_____

PHYSICAL EXAM

Height: _____ Weight: _____ B/P: _____ Pulse: _____ Respirations: _____

SKIN _____ HEART _____

HEAD _____ LUNGS _____

EYES _____ ABDOMEN _____

ENT _____ BACK _____

NECK _____ EXTREMITIES _____

NEUROLOGIC _____

Please describe abnormalities (include any lifting restrictions): _____

_____

IMMUNIZATION HISTORY

[ ] PPD (Mantoux): Date Implanted _____ Manufacturer: _____ Lot #_____

Expiration date:_____ Date Read _____ Results _____(mm) Interpretation _____Read by:_____

[ ] **For Positive PPD or History of positive PPD, where PPD contraindicated**

[ ] Chest X-Ray: Date/Result: _____ (Attach original report)

TB Prophylaxis initiation date: _____, Completion date:_____

[ ] Rubella Titer -Attach lab report Date: _____ Result: _____ [ ] Immune

[ ] Rubeola Titer -Attach lab report Date: _____ Result: _____ [ ] Immune

OR:

[ ] Rubella Immunization (Only if titer shows no immunity): _____

[ ] Rubeola Immunization (Only if titer shows no immunity): 1st Dose _____ 2nd Dose _____

[ ] Influenza Vaccine Date: _____ Lot #_____

WORK CLEARANCE

The above named person is found to be in good mental/physical health. He/she is free from signs and symptoms of habituation or addiction to alcohol, depressants, stimulants, narcotics or other substances that may alter the person's behavior. He/she is free from any condition or communicable disease which could endanger his/her safety as well as the client.

Physician Signature _____ Exam Date _____

Stamp: _____ License No. _____

Submit