

PHYSICAL STATEMENT AND HEALTH STATUS

MEDICAL RELEASE AUTHORIZATION

I _____ (Client name) do hereby authorize _____ (Physician name) to release any information acquired during my medical examination to MedStaff, Inc. I also authorize MedStaff, Inc. to release any information on this statement, relevant to employment, to any of its client facilities.

Client Signature

TUBERCULOSIS AND IMMUNIZATION STATUS

A positive PPD must be followed by Physician contact and a chest x-ray. Some facilities require a two-step PPD, the spacing below allows for documentation of both steps.

| | |
|----------------------|---|
| Date given: _____ | By: _____ |
| Site: R L forearm | _____ |
| Lot # _____ | Exp. Date: _____ |
| Date read: _____ | By: _____ |
| Results: _____ | _____ |
| Induration: _____ mm | <input type="checkbox"/> Non-significant <input type="checkbox"/> Significant reaction |

| | |
|----------------------|---|
| Date given: _____ | By: _____ |
| Site: R L forearm | _____ |
| Lot # _____ | Exp. Date: _____ |
| Date read: _____ | By: _____ |
| Results: _____ | _____ |
| Induration: _____ mm | <input type="checkbox"/> Non-significant <input type="checkbox"/> Significant reaction |

| Test | Date | Positive | Negative |
|---|-------|----------|----------|
| BCG | _____ | _____ | _____ |
| Chest x-ray | _____ | _____ | _____ |
| Urine drug screen (obtained through MedStaff) | _____ | _____ | _____ |

PPD skin test is required annually by MedStaff, Inc. Documented negative chest x-ray is accepted if PPD is positive. (attach radiology report)

PLEASE FILL IN ALL OF THE APPLICABLE BLANKS. Attach laboratory results to this form.

| Disease | (date) | Immune | (date) | Titre | (date) | Pos. | Neg. | Numerical Value |
|------------------|--------|--------|--------|-------|--------|-------|-------|-----------------|
| Measles | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| Mumps | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| Rubella | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| Varicella | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| Other | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| Other | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

| Hepatitis B | Date | Date | Date | Titre | Pos. | Neg. | Numerical Value |
|-------------|-------|-------|-------|-------|-------|-------|-----------------|
| 1. _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

Hepatitis B acknowledgment form must be signed and submitted to MedStaff. Charges for Hepatitis B vaccine will be paid as specified by MedStaff policy.

Does this Healthcare worker have a latex allergy? Yes _____ No _____

There may be additional requirements for employment with MedStaff, a particular healthcare facility and/or standard in the healthcare industry.

HEALTH STATEMENT

I have examined this patient and determined that this person is in good physical and mental health, free of communicable diseases, and able to function and perform all job duties without any physical limitations in his/her profession at full capacity.

Physician Signature _____ License Number _____ Date _____

Physician Address (Please Print) _____

Physician Phone Number _____

PLEASE ATTACH ALL LAB AND RADIOLOGY RESULTS



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