Around the Clock
Healthcare Services
"Staffing...wherever healthcare is provided."

EMPLOYEE HEALTH FORM

(To be completed by physician.)

Name: _____ Date: _____

Social Security Number:_____

EMPLOYEE RELEASE: I authorize the release of the information contained on this form to be provided to ATC Healthcare Services, Inc. for the purposes of maintaining required medical employment records. I understand that this health profile is required in order that I may be considered for assignment with ATC Healthcare Services.

_____ _____
Signature Date

Vaccination History **Titer results must be provided by laboratory printout**

1. MMR (Measles, Mumps, Rubella) Vaccine Date: _____
2. Mumps Vaccine Date_____ Titer ❒Pos ❒Neg
3. Rubella Vaccine Date_____ Titer ❒Pos ❒Neg
4. Rubeola Vaccine Date_____ Titer ❒Pos ❒Neg
5. Varicella Vaccine Date_____ Titer ❒Pos ❒Neg
6. Hepatitis B Series (3 shots) ❒ Yes ❒ No Dates:_____; _____; _____ Titer: ❒Pos ❒Neg
7. Influenza Vaccine: ❒ Yes ❒ No Date: _____
8. TDAP Vaccine ❒ Yes ❒ No Date: _____
9. Latex Allergy: ❒ Yes ❒ No

Tuberculosis Screening (upon employment and annually)

1. Date PPD placed:_____ By_____ Lot#_____ Exp._____
2. Results read at 48- 72 hours in mm_____ Read by _____ Title_____
3. TB Questionnaire (if PPD+): Date: _____
4. Chest X-Ray, if applicable (include report): Date: _____

Physician Certification of Fitness for Duty

I certify that _____ is free from symptoms indicating the presence of an infectious disease and does not have any restrictions which would interfere with the performance of his/her duties performed in the capacity this named position _____.

_____ _____ _____
Physician's Signature License # Date

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INITIAL and ANNUAL TUBERCULOSIS SCREENING QUESTIONNAIRE

(This Form is to be used for those with a previously positive TB Skin Test, i.e., positive PPD.)

Name:_____ **Date:**_____

Positive TB Skin Test (PPD Date):_____

Date of Last Chest X-Ray:_____

Please indicate if you have had any of the following conditions for three to four weeks or longer:

SIGN OR SYMPTOM	YES	NO
Chronic Cough (greater than 3 weeks)		
Production of Sputum (productive cough)		
Blood Streaked Sputum		
Unexplained Weight Loss		
Unexplained Fever		
Weakness/Fatigue/Tiredness		
Loss of Appetite		
Night Sweats		
Shortness of Breath		
Chest Pain with Coughing		
Rapid Heart Rate (Tachycardia)		

PHYSICIAN STATEMENT

Based upon the responses of this questionnaire and my assessment, I find no evidence of pulmonary tuberculosis infection.

Physician Signature:_____ **Date:**_____

License Number_____

Clinic/Office Address:_____

Clinic/Office Telephone Number: _____