A1 Healthcare Staffing
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Comprehensive Health Statement

Name: _____
Address: _____

Physical Exam:

The above individual has been examined and found to be in good health without evidence of communicable disease and free from health conditions which would be of potential risk to the patient or which might interfere with the performance of the person's duties as a health care worker.

Physician or Nurse Practitioner:
Name: _____ Phone Number: _____
Address:_____
Signature: :_____Date: _____

PPD Skin Test: Step 1

TB (Mantoux) Test: Date Given:___Lot #: Circle: Right Forearm or Left Forearm Given By (signature): :_____	Date Read: :_____Reading: :_____ mm Circle: Negative or Positive Read By (signature): :_____
PPD Skin Test: Step 2 (between 1 week and 3 months after step 1, placed in opposite arm) Date Given:_____Lot #:_____ Circle: Right Forearm or Left Forearm Given By (signature): :_____	**Note: recent(within 5 years) Chest X-ray and annual TB checks are required if PPD skin test is positive** Date Read: :_____Reading: :_____ mm Circle: Negative or Positive Read By (signature): :_____

If unable to undergo a TB Test due to a past positive TB Test, a Chest X-Ray is acceptable. Please complete Annual TB Questionnaire form and submit to our office.

Date: _____ Chest X-Ray Results: _____
Please attach radiological report.