Print Form

PRN Consultants

PHYSICIAN'S STATEMENT

NAME: _____

ADDRESS: _____

_____

Please sign, stating that you have examined the above named individual and found her/him to be free from infection and health conditions which would be of potential risk to patients or which might interfere with the performance of the person's duties as a healthcare worker, including, but not limited to the habituation or addiction to substances which may alter the individual's behavior.

DATE OF PHYSICAL EXAM: _____ URINE DRUG SCREEN RESULTS: _____

DATE & RESULTS OF PPD/MANTOUS/TB *(YEARLY REQUIREMENT)*: _____

2nd STEP PPD *(WHERE REQUIRED)* DATE & RESULTS: _____

IF PPD IS/HAS BEEN POSITIVE, A CHEST X-RAY IS REQUIRED.

ARE YOU HAVING FEVER, CHILLS, NIGHT SWEATS, PRODUCTIVE COUGH OR WEIGHT LOSS? ___ Yes ___ No

DATE OF POSITIVE PPD: _____ DATE AND RESULTS OF CHEST X-RAY: _____

COMMENTS: _____

_____

_____

PHYSICIAN NAME: _____
(PLEASE PRINT)

PHYSICIAN SIGNATURE: _____ DATE: _____

PATIENT SIGNATURE: _____ DATE: _____

In accordance with OSHA recommendations, hospitals are requiring a current titer or record of a titer drawn in nurse profile prior to reporting to work for Rubella, Rubeola & Mumps (same as MMR), Varicella (same as chicken pox), and Hepatitis B. Please have these titers drawn and submit lab report to PRN Consultants.

TITER	DATE	IMMUNE
RUBELLA	_____	___ YES ___ NO
RUBEOLA	_____	___ YES ___ NO
MUMPS	_____	___ YES ___ NO
VARICELLA	_____	___ YES ___ NO
HEPATITIS B	_____	___ YES ___ NO