☐ NEW APPLICANT
Attn: _______________

JS Homecare Agency of NY
4318 8th Avenue • Brooklyn, NY 11232-3910
Phone: (718) 686-8866 • Fax: (917) 970-8465

EMPLOYEE PHYSICAL EXAMINATION REPORT

Name:	Date of Birth:	Sex: ☐ M ☐ F
Address:	SS #:	Title:

PHYSICAL EXAMINATION

HEAD/ENT:	CARDIOVASCULAR:
EYES:	MUSCULOSKELETAL:
NECK:	ABDOMEN:
BREASTS:	GENITOURINARY:
LUNGS:	CENTRAL NERVOUS SYSTEM:
COMMENTS:	

HT:	WT:	B/P:	Pulse:	Temp:

LABORATORY TEST RESULTS

TEST	DATE PERFORMED	RESULTS	
RUBELLA TITER		☐NON-IMMUNE ☐IMMUNE	**LAB VALUE:** (*Attach Lab Report)
MEASLES TITER		☐NON-IMMUNE ☐IMMUNE	**LAB VALUE:** (*Attach Lab Report)
QuantiFERON Gold Test	Date:	Results:	*Attach Lab Report
PPD	1. DATE IMPLANTED	1. DATE READ:	RESULTS (mmxmm):
	2. DATE IMPLANTED	2. DATE READ:	RESULTS (mmxmm):
CHEST X-RAY	Date:	Results:	*Attach Lab Report
DRUG SCREEN	Date:	Results: (*Attach Lab Report)	

IMMUNIZATIONS:	DATE	DATE	DATE
RUBELLA	1.		
RUBEOLA/MEASLES	1.	2.	
HEPATITIS B VACCINE	1.	2.	3.
INFLUENZA VACCINATION			

☐ **This individual is free from any health impairment that is a potential risk to the patient or other employee, or which may interfere with the performance of his/her duties including habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol, or other substances that may alter behavior.**

☐ **This individual is able to work with the following limitations:** __________________

☐ **This individual is not physically/mentally able to work.** ***(Specify reason):*** ________________________

Physician Signature:______________________**Physician Print Name**___________________ **Lic. No.** ______________**Date:**_______________

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Habituation Statement

Employee Name: ___________________________ Employee DOB: ______________

I certify to the best of my knowledge that above individual is free from any health impairment that may be of potential risk to the patient or may interfere with the performance of his/her duties, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances that may alter his/her behavior.

I also certify that to the best of my knowledge he/she does not pose any risk to others, and that the above information is accurate.

Physician Print Name: ____________________________________ Lic. No.: ________________

Physician Signature: _____________________________________ Date: ___________________

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Annual TB Screening Questionnaire

Employee Name: ___________________________ Employee DOB: ______________

Please answer the following questions:

	Question	Yes	No
1)	History of Positive TB Test? [TB Skin Test (TST) or T-SPOT, QuantiFERON (IGRA)]	☐ Yes	☐ No
2)	Have the individual had a temporary or permanent residence of ≥ 1 month in a country with a high TB rate in the last 12 months? (Any country other than the Australia, Canada, New Zealand, those in Northern Europe, Western Europe, and the United States)	☐ Yes	☐ No
3)	Are the individual currently immunosuppressed or plan to be on immunosuppressive therapy, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥ 15 mg/day for ≥ 1 month), or other immunosuppressive medication?	☐ Yes	☐ No
4)	Have the individual had close contact with someone who has had infectious TB disease since your last TB screening test or questionnaire?	☐ Yes	☐ No
5)	Do the individual have a cough that has lasted longer than 3 weeks?	☐ Yes	☐ No
6)	Do the individual cough up blood or thick sputum?	☐ Yes	☐ No
7)	Have the individual had a decrease in his/her appetite?	☐ Yes	☐ No
8)	Have the individual lost weight (> 10 pounds) in the last 2 months without trying?	☐ Yes	☐ No
9)	Have the individual experienced night sweats?	☐ Yes	☐ No
10)	Have the individual had an unexplained, persistent low-grade fever?	☐ Yes	☐ No

I certify that to the best of my knowledge that the above information is accurate.

Physician Signature: ____ **Date:** _________________

Physician Print Name: _______________________________________ **Lic. No.** _______________