

# MEDICAL FORM

FirstName: \_\_\_\_\_ Last Name: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Address \_\_\_\_\_ Last Four Digits of Social Security Number: \_\_\_\_\_

Email Address: \_\_\_\_\_ Physical Examination Date: \_\_\_\_\_

If required in your position, would you be willing to have screening tests for drug/alcohol done on your blood/urine as a condition for employment? \_\_\_No \_\_\_Yes

If no, please explain: \_\_\_\_\_

I certify to the best of my knowledge that I am free from any health impairment that may be of potential risk to me or interfere with the performance of my duties. I also certify that to the best of my knowledge, I do not pose any risk to myself or others and that the information below is accurate.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Physician's Office Only

### LabTest Results

PPD/Mantoux/T.B.: Date Placed: \_\_\_\_\_ Date Read: \_\_\_\_\_ Results: \_\_\_\_\_ -OR- \_\_\_ Lab Attached

Quantiferon Gold: Date Placed: \_\_\_\_\_ Date Read: \_\_\_\_\_ Results: \_\_\_\_\_ -OR- \_\_\_ Lab Attached

Positive Reading: Date of Chest X-Raya: \_\_\_\_\_ Results: \_\_\_\_\_

A Mantoux test is required every year, unless previously positive.

### Immunizations/Titres

Hepatitis B Vaccine: 1<sup>st</sup> Date: \_\_\_\_\_ 2<sup>nd</sup> Date: \_\_\_\_\_ 3<sup>rd</sup> Date: \_\_\_\_\_

	Measles	Pertussis	Mumps	Varicella	Rubella/Rubeola Titre	Influenza	Tetanus-Diphtheria (within 10yrs)
Date							
Result							

- Measles vaccine is required as follows: proof of two doses of vaccine, a positive titre, or physician certification of disease if born on or after January 1, 1957
- A Rubella titre is required unless a positive titre is on record.
- A DT immunization is required every ten years to maintain immunity.

If any immunizations were refused: Initials/Date: \_\_\_\_\_

I certify to the best of my knowledge that this individual is free from any health impairment that may be of potential risk to the patient or interferes with the performance of his/her duties. I also certify that to the best of my knowledge, he/she does not pose any risk to self or others and that the above information is accurate.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Physician Name

\_\_\_\_\_  
Date

License Number: \_\_\_\_\_ NPI Number: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please affix stamp: