☐ NEW APPLICANT

Attn: _____

JS Homecare Agency of NY
4316 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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Annual TB Screening Questionnaire

Employee Name: _____ Employee DOB: _____

Please answer the following questions:

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.** _____