



HEALTH ASSESSMENT FORM last revised 3/24/09

Employee Name _____ Social Security # _____
Employee Address _____ Home Phone _____
Examination Date _____ Date of Report _____

PPD #1-Mantox (within one year) Given: _____ Read: _____ Result mm induration [-] _____ Result mm induration [+] _____
PPD #2-Mantox Given: _____ Read: _____ Result mm induration [-] _____ Result mm induration [+] _____

OR

Chest X-Ray: (attach report) Given: _____ WNL [] _____ RF [] _____

Result Immunity Status

Rubella (German Measles) Titer _____ Date _____
Rubeola (American Measles) Titer _____ Date _____
Mumps Titer _____ Date _____
Varicella (Chicken Pox) Titer _____ Date _____

Hepatitis B Surface Antibody HBsAB Results _____ Date _____
(If positive, there is Immunity for Hepatitis B Virus, therefore NO NEED to take Hep B Antigen)

Date(s) of Hepatitis B Vaccinations (Recombivax HB) _____ 1 _____ 2 _____ 3
(Three doses over six month period)

Date(s) of other vaccinations (MMR; Attenuvax; MeruvaxII; Varivax) _____ 1 _____ 2
(Two doses 4-8 weeks apart)

Hepatitis B Surface Antigen Results _____ Date _____

Tetanus (Not Mandatory) Yes _____ No _____ Date _____

Urine Drug Screening: (-) _____ (+) _____ Date _____
(Ten Panel / attach report)

COMMENTS: _____

I have examined _____ and determined that he / she is free of any health impairment which is of potential risk to patients or which might interfere with the performance of his / her duties.

Signature _____ Date _____ LIC# _____

Physician's Name (please print) _____
Physician's Phone _____
Physician's Address _____

(This form is not valid unless stamped by MD / authorized provider.)

NOTE
ALL LAB REPORTS
MUST BE ATTACHED!
STAMP HERE