Physicians Statement

Applicant name: _____ Date: _____

Tuberculosis Screening

	Date Given	Date Read	Results
1 PPD/ TB Skin Test			Induration _____ mm Negative Positive Circle One
2 PPD/ TB Skin Test			Induration _____ mm Negative Positive Circle One
Chest X-ray (if PPD +)*			

*Attach copy of the radiology report and a copy of the +PPD reading.

Immunization Status

Document date of vaccine/titre and results. .

Vaccination	Vaccination Date	Results
TDaP		
MMR Vaccine 1		
MMR Vaccine 2		
Hepatitis B Vaccine 1		
Hepatitis B Vaccine 2		
Hepatitis B Vaccine 3		
Varivax Vaccine 1		
Varivax Vaccine 2		
Titres		
Titre	Titre Date	Results
Rubella Titre		___ Immune ___ Non-Immune
Rubeola Titre		___ Immune ___ Non-Immune
Mumps Titre		___ Immune ___ Non-Immune
Varicella Titre		___ Immune ___ Non-Immune __History
Hepatitis B Titre		___ Immune ___ Non-Immune

The above named patient has been examined by me and found to be in good physical and mental health, free of communicable disease, and able to function without physical limitations as a healthcare professional.

_____

Physician's Signature License Number Date of Exam

_____

Physician's Name City/State Telephone