116-16 Queens Blvd. Suite 204
Forest Hills, NY 11375
Tel: 718.337.1100
Fax: 718.337.1101

PHYSICAL EXAMINATION FOR EMPLOYMENT

Full Name: _____ DOB: _____ Employment Type: □ RN □ HHA □ PCA □ PA

PHYSICAL EXAMINATION BY AUTHORIZED PRACTIONIER

Height: _____ Weight: _____ BP: _____ Pulse: _____ Resp: _____

System	Findings	System	Findings
Head / Ears / Nose / Throat	_____	Vascular System	_____
Eyes / Vision	_____	Abdomen	_____
Endocrine	_____	Upper & Lower Extremities	_____
Chest & Lungs / Pulmonary	_____	Musculoskeletal	_____
Heart / Cardiac	_____	Dermatological	_____
Psychiatric / Mental Status	_____	Neurological	_____

TUBERCULOSIS SCREENING

SYMPTOMS FOR TB	Yes	No	If yes, please explain:
Blood streak sputum	□	□	_____
Chest pain	□	□	_____
Night sweats	□	□	_____
Persistent cough	□	□	_____
Unexplained weight loss	□	□	_____
Loss of appetite	□	□	_____
Exposure to someone with active TB in the past 6 months	□	□	_____
HISTORY OF A POSITIVE PPD			
History of BCG vaccine	□	□	_____
Have you ever been treated for TB?	□	□	_____
Date of last PPD:	_____		Result: _____
Date of last chest x-ray:	_____		Result: _____
Date of PPD conversion:	_____		
Have you ever been treated for PPD conversion?	□	□	_____

VACCINES / BLOOD WORK

- Date 1st PPD: _____ Date Read: _____ Result: _____mm □ Negative □ Positive
- Date 2nd PPD: _____ Date Read: _____ Result: _____mm □ Negative □ Positive
- QuantiFERON Gold: Date Read: _____ Result: □ Negative □ Positive
- Chest X-ray for positive PPD: Date: _____ Result: □ Negative □ Positive
- Rubella: Date of titer: _____ Result: _____ □ Immune □ Non-Immune
  Date of Immunization (MMR): _____
- Rubeola: Date of titer: _____ Result: _____ □ Immune □ Non-Immune
  (Born after Jan. 1, 1957) Date of Immunization (MMR #1): _____ Date of Immunization (MMR #2): _____
- Hepatitis B Immunity: Date of antibodies test: _____ Result: _____ □ Immune □ Non-Immune
  Date of Immunization #1: _____ #2: _____ #3: _____ Declination: □ Yes □ No
- SARS CoV2 2019 Vaccination #1 Lot#: _____ Manufacturer: _____ Date: _____
- SARS CoV2 2019 Vaccination #2 Lot#: _____ Manufacturer: _____ Date: _____
- SARS CoV2 2019 Vaccination MD Exempt? □ Yes □ No If yes, ***Please attach exemption letter***
- Urinalysis Drug Screen Date: _____ Result: □ Negative □ Positive
- Seasonal Flu Immunization: Date: _____ Declination: □ Yes □ No

PLEASE ATTACH LAB REPORTS

MEDICAL EXAMINER

I hereby certify that the above-named patient does not have any limitation for employment. There is no health impairment present that is of potential risk to employee, patient, family, or other employee that may interfere with the performance of duties. In addition, to the best of my medical judgment and knowledge, the patient has no habituation of addictions to depressants, stimulants, narcotics, alcohol or other drugs. This is based on my medical assessment and interview with patient.

Date of Examination: _____

Physician's Name (print): _____ Physician's Signature: _____

Address: _____

License #:_____ Phone #:_____

Official Physician Stamp Here:

MD OFFICE, please fax this completed form along with lab reports to 718-337-1101. Thank you.

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Employee's Name: _____ Title: _____

HEPATITIS-B VACCINE CONSENT/ DECLINATION

I acknowledge that I am at risk of exposure or have been unknowingly exposed to the Hepatitis-B virus as a result of my employment and acknowledge that the agency will arrange for me to receive the Hepatitis-B vaccine. I have read the information sheet concerning the disease, the vaccine and possible adverse reactions to the inoculation. Additionally, I have asked questions which I may have had, and they have been fully answered to my satisfaction. I hereby make the decision to:

_____ request that I receive the Hepatitis-B vaccine

__✔__refuse the Hepatitis-B Vaccine and hold harmless the agency. I understand that due to my occupational exposure to blood or potentially infectious materials, I may be at risk of acquiring the Hepatitis-B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis-B vaccine, at no charge to myself. However, I decline the Hepatitis-B vaccination at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring Hepatitis-B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potential infectious materials and want to be vaccinated with the Hepatitis-B vaccine, I can receive the vaccination series at no charge to me.

_____ provide written proof of immunity (attach supportive documentation)

_____ provide written proof of previous vaccination (attach supportive documentation)

_____ provide written proof of medical contraindication (attach supportive documentation)

_____ refuse the Hepatitis-B titer

Employee's Signature: _____ Date: _____

Supervisor or Witness: _____ Date: _____

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Declination of Influenza Vaccination

For Health Care Personnel

Employee's Name: _____ Employee's ID#:_____

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms
  are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and,
  even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to
  my health and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.
- **Because I have refused vaccination against influenza, I will be required to wear surgical or procedure masks in areas where patients or residents may be present during the influenza season.**

I acknowledge that I have read this document in its entirety and fully understand it. Despite these facts, I have decided to decline the influenza vaccine by my signature below. I realize that I may re-address this issue at any time and accept vaccination in the future.

Signature: _____ Date: _____

Witness: _____ Date: _____

MD OFFICE, please fax this completed form along with lab reports to 718-337-1101. Thank you.