HELPING HANDS

HOMEMAKING SERVICE FOR CHRONICALLY ILL, INC.

Nassau (516) 489- 6810 **FAX: (631) 261-3083** Suffolk (631) 261-0403

MEDICAL FORM

Name____ Date of Birth: ____________________

Address:____ Telephone: (   ) _________________

I consent to this examination and release of information:
Signature:____ Date:_____________________________

. . . .

To be completed by physician only *Note to physician:*
In making your medical evaluation of the above patient, please be aware that he/she will be employed as a health care provider, which may involve homemaking and/or patient care. We are interested in this person's ability to function in this capacity.

PHYSICAL EXAMINATION:		NORMAL	ABNORMAL	Comment, if Abnormal:
Height:____________	EYES:			
	EARS:			
Weight:____________				
	NOSE:			
Blood Pressure:______	THROAT:			
	LUNGS:			
Pulse:______________				
	HEART:			
Respiration:_________	BACK:			

LABORATORY TESTS:

RUBELLA	Date of Titer/Titer # & immune status:	OR immunization record:
MEASLES (If born after 1/1/1957)	Date of Titer/Titer # & immune status:	OR immunization record:
TUBERCULOSIS (within past 3 months)	PPD or Quantiferon Gold Date/Results: OR	TB Screen or Chest X-ray: Date/Results:

DRUG SCREEN Date NEG POSITIVE (attach report)

FLU VACCINE Date COVID-19 VACCINE Date #1 Date #2

If the above named patient has any disabilities, physical or neurological restrictions that could interfere in the performance of his/her duties please indicate type and degree of restriction.____

I certify that I have conducted physical examination of the above named person & find no evidence of any health impairments that pose a potential risk to patients. This person can work in a healthcare setting without restrictions. He/she is free of any communicable disease, is asymptomatic of tuberculosis and is free from habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the individual's behavior & interfere in the performance of duties.

Physician's signature: _______________________

Date of examination: _______________________

Physician's stamp: