GRACE Staffing Inc.

Health Statement

Patient Name:_____ Social Security:_____
Printed

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

Date of Exam:_____

Provider's Printed Name:_____

Title of Provider ☐**MD**☐**DO**☐**NP**☐**PA**

Provider's Signature:_____

License Number:_____

Office Phone Number:_____

I authorize my physician to release my health records to Grace Staffing Inc. I realize Grace Staffing Inc will release my health records to client facilities as a condition of placement as required by JCAHCO standards.

_____ _____

Employee Signature **Date**

TB Screening Questionnaire

Positive TB skin test (PPD) Date:_____

Last chest X-Ray Date:_____

Please indicate if you are having any of the following problems for three to four weeks or longer:

1.	**Chronic cough (longer than 3 weeks)**	**Yes**☐ **No**☐
2.	**Production of Sputum**	**Yes**☐ **No**☐
3.	**Blood-Streaked Sputum**	**Yes**☐ **No**☐
4.	**Unexplained Weight Loss**	**Yes**☐ **No**☐
5.	**Fever**	**Yes**☐ **No**☐
6.	**Fatigue/Tiredness**	**Yes**☐ **No**☐
7.	**Night Sweats**	**Yes**☐ **No**☐
8.	**Shortness of Breath**	**Yes**☐ **No**☐

NO EVIDENCE OF PULMONARY TUBERCULOSIS OF CONTAGIUM.

_____ _____

Date **Agency Personnel Signature**