TRIMED HEALTHCARE, LLC
Nurse Assistant/Home Health Aide/ Patient Care Aide- EMPLOYEE
PHYSICAL EXAMINATION FORM

Name _____ (Sex) M____ F____ Birthdate_____

Address _____ City_____ State___ Zip_____ Phone_____

_____

REQUIRED TUBERCULOSIS SCREENING

Two Step PPD:
P.P.D. (Within 6 months) Date _____Results Chest X-ray (If P.P.D. is positive) Date Results_____

P.P.D. (Within 6 months) Date _____Results Chest X-ray (If P.P.D. is positive) Date Results_____

RECOMMENDED IMMUNIZATIONS: Not required.
Please give dates and provide copy of immunization record or serological confirmation.

Diphtheria & Tetanus 1st_____ 2nd_____ 3rd_____ Booster required every 10 years.
Polio (completed series) 1st_____ 2nd_____ 3rd_____ Booster (year taken)
Rubeola 1st_____2nd___ or documented physician diagnosis of serological immunity
Rubella Date given_____ or serological confirmation of immunity_____

The above named has no communicable or disabling disease nor health condition that would create a hazard to himself or herself, visitors, consumers or patients at this time. He/she is able to perform the physical activities required for the delivery of direct care.
Should the 2 Step PPD or chest X Ray be arranged and paid for by TrMED Healthcare, the costs will be deducted from applicants subsequent payroll. Chest X Ray $65.00
Please authorize the deduction with your signature below:

Employee Signature:_____Date:_____

Examiner name and signature: _____Date_____

Address_____Phone:_____

I give permission to release a copy of this form to affiliating clinical facility.

Employee signature _____ Date: _____

ATTACH P.P.D. AND CHEST X-RAY RESULT FORMS TriMED Healthcare, LLC