



PHYSICIAN'S STATEMENT

Name: _____ Last First

SS# _____ Title: _____ Branch: _____

has applied for assignments through Access Nursing Services. Please complete all sections that you have knowledge of, and sign this form stating that you have examined the above-named individual and have found her/him to be in good health and free from all communicable diseases. Thank you

TB Screen: PPD Mantoux: _____ Date Results
2nd PPD Mantoux: _____
Chest x-ray (if PPD positive): _____

If PPD positive, does the employee require prophylactic Tuberculin medication: [] Yes [] No
Meds Prescribed: _____

Rubella (German Measles) Titer: _____
Follow-up Titer: _____ Immune Non-Immune

If Non-immune give immunization date _____

Rubeola (born after 1/1/57) Titer: _____
Follow-up Titer: _____ Immune Non-Immune

If Non-immune give immunization date _____

*VARICELLA TITER: _____ Immune Non-Immune

If Non-immune give immunization date _____

*MUMPS: _____ Immune Non-Immune

Hepatitis B Antigen: _____
Vital Signs : BP: _____ TPR: _____

Drug Use/Abuse Yes No Comments
Depressants [] []
Stimulants [] []
Narcotics [] []
Other (specify) [] []
I.V. substance [] []
Alcohol [] []

Physical Exam: Normal Abnormal If Abnormal, Comments
Skin [] []
HEENT [] []
Neck [] []
Chest [] []
Lungs [] []
Heart [] []
Abdomen [] []
Extremities [] []
Neurological [] []

Color Blindness Test (ISHiHARA) Passed [] Failed []

Comments: _____

MD Name Address

MD Signature MD License # Date