HomeCompanionSolutions

Comprehensive Health Statement

Name of Patient (Please Print): _____ **Date:** _____

Annual Health Statement

The above individual has been examined by me and found to be in good health without evidence of communicable disease. They are able to perform their job duties at full capacity with no limitations and have no medical condition that would be aggravated or interfere with the use of respiratory protection.

Physician or Nurse Practitioner:

Name: _____ Phone Number: _____

Address: _____

Signature: _____ Date: _____

TB Assessment

Step 1: Date applied: _____ Date Read: _____ Results: _____

Step 2: Date applied: _____ Date Read: _____ Results: _____

If unable to undergo a TB Test due to a past positive TB Test, a Chest X-Ray from the past five years is acceptable. Please submit a copy of the Chest X-Ray results and complete The Nurse Agency Annual TB Questionnaire form.

Chest X-Ray Date: _____ Results: _____

Physician or Nurse Practitioner:

Name: _____ Phone Number: _____

Address: _____

Signature: _____ Date: _____

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