NOVA
HOME CARE & STAFFING

_____
Employee Name (Please Print)

## EMPLOYEE HEALTH FORM

☐ **STATEMENT OF SATISFACTORY HEALTH** **([√] IF THIS SECTION IS TO BE COMPLETED)**

_____ is found to be in good health without evidence of communicable disease and free of work restrictions on this date. ☐ Date of last physical exam: _____

Date of 1st Mantoux: _____ Results: _____ MM Date: _____ Signature/Title: _____

Date of 2nd Mantoux: _____ Results: _____ MM Date: _____ Signature/Title: _____

Date of Chest X-ray: _____ Results: _____

☐ Repeat Chest X-ray required on ____/____/____ ☐ Other: _____

☐ Repeat Chest X-ray with development of symptoms

Signed: _____ Date: _____
Physician, Licensed Nurse Practitioner or Physician's Assistant

☐ **EMPLOYEE HEALTH HISTORY ([√] IF THIS SECTION IS TO BE COMPLETED)** **DATE: _____**

COMPLETED BY: ☐ SUPERVISING RN ☐ PHYSICIAN/LICENSED NURSE PRACTIONER/PA

| Yes/No | | | Yes/No | | | Yes/No | | | Yes/No In the last 12 months: | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Diabetes | ☐ | ☐ | Shortness of Breath | ☐ | ☐ | Stroke | ☐ | ☐ | Hospitalized |
| ☐ | ☐ | Heart Disease | ☐ | ☐ | Asthma/Bronchitis | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Lung Disease |
| ☐ | ☐ | Tuberculosis | ☐ | ☐ | Epilepsy/Seizures | ☐ | ☐ | Unexplained Fever | ☐ | ☐ | Back/Spinal Problems |

Do you have any of these conditions or any other conditions which might cause risk to the patient or could potentially interfere with the performance of one's duties, including the habituation of alcohol or current addiction to depressants, stimulates, narcotics, or other substances?

Do any of these conditions impair your ability to perform the essential functions of the job? Yes / No If "yes", explain/give dates: _____

| | Had Disease | | Dates (Month/Year) | | | | | Had Disease | | | Dates (Month/Year) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Disease** | **Yes** | **No** | **Year** | **Titer** | **Results** | **Vaccination** | **Disease** | **Yes** | **No** | **Year** | **Titer** | **Results** | **Vaccination** |
| Chicken Pox | | | | | | | Mumps | | | | | | |
| Measles (Rubeola) | | | | | | | German Measles (Rubella) | | | | | | |

Employee Signature: _____ Practitioner Signature/Title: _____

☐ **EMPLOYEE HEALTH EXAMINATION RECORD ([√] IF THIS SECTION IS TO BE COMPLETED)**

Blood Pressure: ____T ____P ____R Height: ____ Weight: ____ May safely wear HEPA mask: ☐ Yes ☐ No If "No", explain: _____

| | | | | | |
|---|---|---|---|---|---|
| Ears: | | Abdomen: | | Hernia: | |
| Eyes: | | GU History: | | GI History: | |
| Teeth: | | Skin: | | Extremities: | |
| Nose & Throat: | | Scars: | | Other: | |
| Lungs: | | Heart: | | Illnesses/Operations/Injuries: | |

Physical accommodations required to perform essential functions of the job? If applicable, please explain: _____
_____

_____ is found to be in good health without evidence of communicable disease, is free from health impairment, which may cause risk to the patient or which might interfere with his or her duty including the habituation of alcohol, addiction to depressants, stimulants, narcotic or other drugs or substances which may alter your behavior.

Signed: _____ Date: _____
Physician, Licensed Nurse Practitioner or Physician's Assistant