# HEALTH STATUS STATEMENT FORM

**This physician's statement must be completed before you can begin any assignment with TDY. Please DO NOT delay sending your completed application and other forms. This statement may be sent at a later date, but must be sent prior to the start of your employment.**

**APPLICANT INFORMATION:** (Please Print)

Name: ________________________________________________________________________

Home Address: ________________________________________________________________

City: ______________________ State: _________________ Zip code: ________________

**TESTS PERFORMED:** (Applicant must have TB skin test performed unless contraindicated by MD)

TB Skin Test: Date Performed ___/___/___* Date Read ___/___/___* Results____________

2nd Step TB Skin Test: Date Performed ___/___/___* Date Read ___/___/___* Results____________

**TB skin test is contraindicated: Yes___ No___ (If yes refer to chest x-ray)**

Chest X-Ray (if skin test, N/A): Date Performed ___/___/ ___*

Results/Evidence of tuberculosis?:_____________________________________________________

Reason chest x-ray performed:

____history of positive PPD _____allergy to serum ____ other (provide details) ________________

- **<u>TB test results must be current within a year of employment with TDY Medical Staffing,.</u>**
- **<u>Chest X-ray results must be current within two years of employment with TDY Medical Staffing .</u>**

**<u>IMMUNIZATION RECORDS</u>**

| | | |
|---|---|---|
| Mumps Titer or Vaccine: | Date Performed: ___/___/ ____ | Results: _______________ |
| Rubella Titer / or Vaccine: | Date Performed: ___/___/ ____ | Results: _______________ |
| Rubeola Titer / or Vaccine: | Date Performed: ___/___/ ____ | Results: _______________ |
| Varicella: | Date Performed: ___/___/ ____ | Results: _______________ |
| Hepatitis Vaccine 1: | Date Performed: ___/___/ ____ | Results: _______________ |
| Hepatitis Vaccine 2: | Date Performed: ___/___/ ____ | Results: _______________ |
| Hepatitis Vaccine 3: | Date Performed: ___/___/ ____ | Results: _______________ |
| Hepatitis Titer (if vac, N/A): | Date Performed: ___/___/ ____ | Results: _______________ |

**HEIGHT/WEIGHT** (as applicable, per state licensing requirements):
Height: _______Weight: _______N/A:___

**PHYSICIAN/PRIMARY CARE PRACTITIONER'S STATEMENT:**

*I certify that the patient named above has been examined by me and found to be in good physical and mental health. Furthermore, they are free from communicable diseases and are able to perform the essential functions of the position for which he/she is applying.*

**Date of exam:** ___/___/ ____

**Additional Comments:** ________________________________________________________

Name of Physician/Primary Care Practitioner (PCP): ____________________________________

License #:___________________

Physician/PCP's Address: ______________________________________________________

City: _________________ State: _________________ Zip code: __________________

Physician/PCP's Signature: _____________________________________Date: ___/___/ ____

**TDY MEDICAL STAFFING, INC.**

**TDY GOVERNMENT SERVICES**

www.tdymedical.com

# POST OFFER/PRE-EMPLOYMENT PHYSICAL EXAMINATION WAIVER

I hereby request a waiver of a physical examination and release TDY Medical Staffing, Inc. (TDY) of any and all liabilities that may thus develop due to the lack of a physical examination. I also accept the responsibility for my physical well-being while employed at TDY and I understand that TDY reserves the right to request a physical examination. I further understand that if I have a pre-existing medical condition that could be or is aggravated while employed by TDY, that it must be reported to TDY. I agree that I will not partake in any activity which could aggravate a pre-existing medical condition. Information provided to TDY regarding your health is to be used for the planning of facilities and in no way affects your employment with TDY. TDY complies fully with Section No. 504 of the Rehabilitation Act of 1973 and Americans with Disabilities Act (ADA) of 1990.

_________________________________ ________________

Applicant's Signature Month / Day / Year

Last 4 digits of Social Security Number: _________________ Birthdate: ____________________

Name:

______________________________________________________________________________

(Last) (First) (Middle)

Address: _____________________________________________ Telephone: ________________________

**PLEASE READ, SIGN, COMPLETE AND FAX BACK WITHIN 3 DAYS OF RECEIPT TO 215-839-3442**