

**HEALTH SCREENING REPORT - FACILITY PERSONNEL**

All personnel, including applicant, licensee or employed staff of Residential Care Facilities for the Elderly, Community Care or Child Care Facilities must demonstrate that their health condition allows them to perform the type of work required. This health appraisal is to be completed by or under the direction of a physician.

**A health screening, by or under the direction of a physician must have been performed not more than one year prior to employment or within seven (7) days after employment.**

FACILITY NAME

FACILITY ADDRESS

PERSON'S NAME		AGE	
POSITION TITLE	TYPE OF FACILITY	WORK DAYS PER WEEK	WORK HOURS PER DAY
DUTY STATEMENT			

## TYPES OF PERSONS SERVED (Check appropriate items)

- Infants       Adults       Developmentally Disabled       Physically Handicapped  
 Children       Elderly       Mentally Disordered       Drug/Alcohol Addiction  
 Other (specify) \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT.

SIGNATURE OF APPLICANT/LICENSEE OR EMPLOYEE	ADDRESS	DATE
---	---------	------

**NOTE TO PHYSICIAN:** Personnel in Residential Care Facilities for the Elderly, Community Care or Child Care Facilities shall be free from communicable disease, and capable of performing assigned tasks. Please complete the following information on the above named person.

EVALUATION OF GENERAL HEALTH

---



---



---

EVALUATION OF ABILITY TO PERFORM WORK DESCRIBED IN THE ABOVE DUTY STATEMENT

---



---



---

NOTE ANY HEALTH CONDITION THAT WOULD CREATE A HAZARD TO THE PERSON, CLIENTS, CHILDREN OR OTHER PERSONNEL


---



---



---

DATE OF T.B. TEST	<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE	ACTION TAKEN (IF POSITIVE)
DATE OF HEALTH SCREENING	NAME OF PHYSICIAN (PHYSICIAN'S STAMP)	DATE
HEALTH SCREENING BY: (ORIGINAL SIGNATURE)		TELEPHONE #
		DATE