



HEALTH STATEMENT
(To be completed by a Physician)

Name of Patient _____ Last four digits of SS# _____

Procedure	
<input type="checkbox"/> TB Skin Test	_____
OR	Date/Results
<input type="checkbox"/> Chest X-Ray	_____
	Date /Results
<input type="checkbox"/> Rubella Titer*	_____
	Date/Results
<input type="checkbox"/> Measles**	_____
	Date/Results
<input type="checkbox"/> Anti HBs Titer**	_____
	Date/Results
<input type="checkbox"/> Varicella Titer**	_____
	Date/Results
	<input type="checkbox"/> TB Counseling Form

	Titer
	<input type="checkbox"/> N/A
	<input type="checkbox"/> N/A
	<input type="checkbox"/> N/A

* Required
 ** Recommended. May be required by some facilities and/or to work in certain areas. Rubella Titer and Varicella for NICU and nursery workers.

Date of Physical Exam _____

General Appearance: Good Fair Poor

The above named patient has been examined by me and found to be in good physical and mental health. The patient appears to be free of any back problems, free from communicable diseases, and is able to function without restriction.

Physician Signature _____ Date _____

Physician Name: (please print) _____ License Number _____

Physician Address _____