



PHYSICIAN'S STATEMENT-PHYSICAL

This **Physicians Statement** must be completed and signed by the Skipstone Healthcare Staffing employee working in a healthcare profession, and your Physician, and returned to Skipstone Healthcare Staffing prior to placement in an assignment. Skipstone Healthcare Staffing Employee must complete and sign Sections I-II while including any supporting documents. The Physician, completing your physical, must complete and sign section III and attach any supporting documents.

Placement into an assignment will not begin prior to receiving these necessary documents.

Section I.

Employee Name: _____ Position: _____

Address: _____

Date of Birth: _____

S.S. #: _____

Section II. Have you had the following? (Please attach copies of results if possible).

	DATE	RESULT	DATE	RESULT
A. PPD (Tuberculin)*	_____	_____	_____	_____
B. Chest X-ray (Positive PPD only)	_____	_____	_____	_____
C. Rubella Titre	_____	_____	_____	_____
D. Rubeola Titre	_____	_____	_____	_____
E. Varicella Titre	_____	_____	_____	_____
F. Tetanus Booster	_____	_____	_____	_____
G. Hepatitis Vac. 1	_____	_____	_____	_____
H. Hepatitis Vac. 2	_____	_____	_____	_____
I. Hepatitis Vac. 3	_____	_____	_____	_____

Test (if positive, referral for chest x-ray required)

I understand that I must have an annual physical/health screening and an annual PPD to maintain active employment with Skipstone Healthcare Staffing. I hereby give my permission to release the results of any test and/or information regarding my health condition/status to Skipstone Healthcare Staffing for employment purposes.

Employee Signature

Date

Section III. To be completed by the Physician/Examiner-(Proof of Physical)

Physician Comments:

Date of Exam: _____

I certify that the above person, to the best of my knowledge, is in good physical and mental health, free from symptoms indicating the presence of an infectious disease and does not have any condition which would interfere with the performance of his/her duties which may require: assistance with transfers; supporting patient during ambulation; providing personal care; and skilled nursing function. I have also included any and all supporting documents.

Physician's Signature: _____

Date: _____

Physician's Address: _____

Phone Number: _____