



When Quality and Integrity go hand in hand.

PHYSICIAN'S STATEMENT

Name: _____ Date: _____

Physician (Print): _____ Telephone: _____

Please circle answers with a YES or NO. This health questionnaire is for the purpose of assisting your employer in placing you in a job safe to yourself and others according to your physical ability.

Have you ever filed a claim or received benefits for an occupational injury, disease, or accident?	Yes	No
Been refused insurance for health reasons?	Yes	No
Have you ever had any back/spinal problems?	Yes	No
Have you ever had any form of hepatitis?	Yes	No
Have you ever had heart problems including irregular heartbeats?	Yes	No
Have you ever had liver disease or kidney disease?	Yes	No
Have you have diabetes or been treated for diabetes?	Yes	No
Have you ever had mental disorder?	Yes	No
Do you have an existing temporary medical condition?	Yes	No
Have you ever had cancer, tuberculosis, or blood disorder?	Yes	No

HAVE YOU DEVELOPED ANY OF THE FOLLOWING IN THE LAST YEAR:

Are you a smoker?	Yes	No
Have you had a persistent cough?	Yes	No
Have you had persistent skin rashes, abscesses, or sores?	Yes	No
Do you have excessive fatigue despite adequate rest?	Yes	No
Have you had diarrhea lasting more than 48 hours?	Yes	No
Have you had an unexplained change in your weight?	Yes	No
If so, how much weights have you lost? _____		
Are you having any unexplained elevation of temperature?	Yes	No

EXPLANATION OF ALL QUESTIONS ANSWERED YES ABOVE:

PLEASE PROVIDE 24/7 SS WITH YOUR PHYSICAL AND TUBERCULOSIS STATUS ANNUALLY.

PPD	SITE	RESULTS:	CHEST X-RAY DATE:	RESULTS:
Date Given:				
Date Read:		_____mm		

If you have a positive PPD, a baseline **Chest X-Ray** is required and then required every 4 years thereafter.

If you have a **Chest X-Ray** please attach the **Radiology Report** to this Form.

Rubella/Immunization: [] Yes [] No	(If Yes)Date Immunized:_____
Date Titer Drawn:	[] Immune
Date of Result:	[] Non-Immune

Rubeola/Immunization: [] Yes [] No	(If Yes)Date Immunized:_____
Date Titer Drawn:	[] Immune
Date of result:	[] Non-Immune

Mumps/Immunization: [] Yes [] No (If Yes)Date Immunized:_____

Date Titer Drawn: _____ [] Immune

Date of result: _____ [] Non-Immune

Varicella/Immunization: [] Yes [] No	(If Yes)Date Immunized:_____
Date Titer Drawn:	[] Immune
Date of result:	[] Non-Immune

Hepatitis B/Immunization	[] Yes	[] No
Vaccine Dates Given: Dose 1		
Dose 2		
Dose 3		
OR Signed Waiver: <small>(Waiver only valid for Hep B)</small>		

RESULTS: **Please stamp area above with Dostor's Office Stamp.**

The aforementioned individual is found to be physically and mentally capable, free from communicable diseases, able to perform assigned duties without limitation, and has no apparent health condition that would cause a hazard to patients or others.

Physician's name

Physician's ID number

Physician's signature

Date

Physician's address