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PHYSICAL EXAM/COMMUNICABLE DISEASE CLEARANCE

INSTRUCTIONS:

This form must be completed and signed by a physician prior to your first assignment with Innovative Staffing Solutions, Inc. and annually thereafter. Please have the physician who has examined you within the past one (1) year complete this form and return it to Innovative Staffing Solutions, Inc. If an examination is necessary for the completion of this form, the expense of this examination will **NOT** be incurred by Innovative Staffing Solutions, Inc.

I certify that _____ has been examined by me on _____ and is in good health and able to work in his/her usual nursing occupation, and is free from any symptom indicating presence of communicable/contagious diseases.

Please fill in blanks that apply: (NEW HIRES ONLY)

Measles -	Disease _____	Immunization _____	Titer _____	Pos. _____	Neg. _____
Mumps -	Disease _____	Immunization _____	Titer _____	Pos. _____	Neg. _____
Rubella -	Disease _____	Immunization _____	Titer _____	Pos. _____	Neg. _____
Varicella -	Disease _____	Immunization _____	Titer _____	Pos. _____	Neg. _____

PPD Skin Test: Date Administered: _____ Date Read: _____ Result: _____

NOTE: If positive, a chest x-ray and completion of TB Screening Questionnaire are required.

Chest X-Ray**: Date: _____ Result: _____ (Within 5 years of date of hire.)

Physician's Signature: _____ Date: _____

Printed Physician's Name: _____

Physician's Address: _____

Physician's Telephone: _____