ALLEN MEDICAL STAFFING INC.

P: (718) 364-7250 F: (718) 364-7355

AGENCY PRE-EMPLOYMENT HEALTH EXAMINATION BY PRIVATE PHYSICIAN

Name _____ Title_____ Department_____
Last First

Date of Birth: _____ Social Security # _____

1. **TO PHYSICIAN:** *A pre-employment health examination is required for the above-named health care worker. Please enter details of all requested information. All fields are required. Thank you.*

2. **MEDICAL HISTORY:**
   - Any major illness or health impairment_____
   - Hospitalization_____
   - Serious injury_____
   - Allergy_____
   - Medication currently being taken:_____

3. **PHYSICAL EXAMINATION:**

   T_____ P_____ R_____ BP_____ Hght_____
   Wght_____
   Gen_____ HEENT_____ Neck_____
   Lungs_____ Heart_____ Abd_____ Ext_____
   Musculoskeletal_____ Neuro_____

4. **TWO (2) PPD TESTS (Mantoux) are required:**
   - **PPD TEST 1** Date: _____ (within last 12 months) Result: _____ (mm)
     (mm/dd/yy)
   - **PPD TEST 2** Date: _____ (within past 3 months) Result: _____ (mm)
     (mm/dd/yy)

5. **CHEST X-RAY** (for positive PPD) Date**:** _____ Result**:** _____
   (mm/dd/yy)

6. **RUBELLA** antibody titer: _____ date: _____ OR vaccine date: _____
   (mm/dd/yy) (mm/dd/yy)

7. **RUBEOLA**
   - *REQUIREMENTS FOR ALL MILLENNIUM EMPLOYEES*

born before January 1, 1957: antibody titer: _____ date: _____
(mm/dd/yy)

OR

2 doses of Live vaccine dates: (1) _____ *(2)* _____
(mm/dd/yy) (mm/dd/yy)

born Jan 1, 1957 – Dec 31, 1966:
if antibody positive, one dose live vaccine required; if antibody negative, 2 doses live vaccine required;
if no antibody test, 2 doses live vaccine required.

antibody test result: _____ antibody test date: _____
(mm/dd/yy)

Live rubeola vaccine dates: (1) _____ (2) _____
(mm/dd/yy) (mm/dd/yy)

born on or after January 1, 1967: antibody titer: _____ date: _____
(mm/dd/yy)

OR

2 doses of live vaccine dates: (1) _____ (2) _____
(mm/dd/yy) (mm/dd/yy)

8. VARICELLA antibody titer: _____ date: _____
(mm/dd/yy)

9. HEPATITIS B surface antibody titer: _____ date: _____
(mm/dd/yy)

vaccine dates: (1) _____ (2) _____ (3) _____
(mm/dd/yy) (mm/dd/yy) (mm/dd/yy)

OR

- HEPATITIS B DECLINATION FORM

10. MUMPS antibody titer: _____ date: _____
(mm/dd/yy)

OR

vaccine dates: (1) _____ (2) _____
(mm/dd/yy) (mm/dd/yy)

11. ADULT TETANUS / DIPTHERIA VACCINE (within 10 years) date: _____
(mm/dd/yy)

12. INFLUENZA VACCINE date: _____
(mm/dd/yy)

13. OTHER REQUIREMENTS:

- 10-PANEL DRUG SCREENING (TOXICOLOGY)
- RESPIRATORY FIT-TEST (N-95)

Physician Name printed or stamp: _____

License number: _____ State: _____

Address: _____

_____

_____

Telephone: _____

_____ _____
Physician Signature Date