

# Supplemental Health Care <sup>SM</sup>

STAFFING SPECIALISTS

2005 SHERIDAN DRIVE • BUFFALO • NEW YORK • 14223 • WWW.TRAVELNURSES.COM  
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## Employee Health Statement/Release

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I, \_\_\_\_\_, do hereby authorize release to Supplemental Health Care and any of its client hospitals or institutions any information acquired in my recent medical examination which is relevant to my employment.

**Signature**       **Date** \_\_\_\_\_

<b>Dates &amp; Results of Your Last:</b>	
<b>Please Attach Documentation or Fax Results to Recruitment/Compliance Department:</b>	
<b>*Annual TB Skin Test (PPD):</b> Date Given: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date Read: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Result:	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest X-ray (If applicable/positive PPD):	
<b>*MMR Vaccination - Proof of Vaccination or Positive Titers of all Three Components</b>	
<input type="checkbox"/> #1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> #2	
<input type="checkbox"/> Mumps Titer Date: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Results:	
<input type="checkbox"/> Rubeola (Measles) Titer Date: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Results:	
<input type="checkbox"/> Rubella (German Measles) Titer Date: <input type="checkbox"/> <input type="checkbox"/> Results:	
<b>*Hepatitis B Immunization Series or Positive Hepatitis B Titre:</b> <input type="checkbox"/>	
<input type="checkbox"/> #1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> #2 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> #3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> Hepatitis B Titer Date: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Results:	
<b>The Following Documentation may be Required - Please check with Recruitment/Compliance Department:</b>	
2 Step PPD <input type="checkbox"/> <input type="checkbox"/> #1 Date Given: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date Read: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Result:	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> #2 Date Given: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date Read: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Result:	
Varicella Immunization: #1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> #2	
Varicella (Chickenpox) Titer Date: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Results:	
Tetanus Immunization (Within 10 Years):	
Other:	

**Allergies Pertinent to the Job (i.e. Latex Allergy):** No: \_\_\_\_\_ Yes/Explain: \_\_\_\_\_

**Physician/Qualified Health Provider Statement**  
 (To be completed by MD, DO, Nurse Practitioner or PA)

I have examined the individual named above, and to the best of my knowledge, he/she is in good physical and mental health, free of any communicable diseases, and is able to function in his/her profession in full capacity.

**Physician/QHP Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician/QHP Name (Please Print):** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Physician/QHP Address:** \_\_\_\_\_