

HEALTH SCREENING REPORT – FACILITY PERSONNEL

All personnel, including applicant, licensee, or employed staff of Residential Care Facilities for the Elderly, Community Care or Child Care facilities must demonstrate that their health condition allows them to perform the type of work required. This health appraisal is to be completed by or under the direction of a physician.

		FACILITY NAME	
		FACILITY ADDRESS	
PERSON'S NAME		AGE	
POSITION TITLE	TYPE OF FACILITY	WORK DAYS PER WEEK	WORK HOURS PER DAY
DUTY STATEMENT			

TYPES OF PERSONS SERVED *(Check appropriate items)*

- | | | | |
|---|----------------------------------|---|---|
| <input type="checkbox"/> Infants | <input type="checkbox"/> Adults | <input type="checkbox"/> Developmentally Disabled | <input type="checkbox"/> Physically Handicapped |
| <input type="checkbox"/> Children | <input type="checkbox"/> Elderly | <input type="checkbox"/> Mentally Disordered | <input type="checkbox"/> Drug/Alcohol Addiction |
| <input type="checkbox"/> Other <i>(specify)</i> _____ | | | |

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT

SIGNATURE OF APPLICANT/LICENSEE OR EMPLOYEE	ADDRESS	DATE
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NOTE TO PHYSICIAN: *Personnel in Residential Care Facilities for the Elderly, Community Care or Child Care Facilities shall be free from communicable disease, and capable of performing assigned tasks. Please complete the following information on the above named person.*

EVALUATION OF GENERAL HEALTH

EVALUATION OF ABILITY TO PERFORM WORK DESCRIBED IN THE ABOVE DUTY STATEMENT

NOTE ANY HEALTH CONDITION THAT WOULD CREATE A HAZARD TO THE PERSON, CLIENTS, CHILDREN OR OTHER PERSONS

DATE OF T.B. TEST	<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE	ACTION TAKEN (IF POSITIVE)
DATE OF HEALTH SCREENING	NAME OF PHYSICIAN (PHYSICIAN,S STAMP)	DATE
HEALTH SCREENING BY: (ORIGINAL SIGNATURE)		TELEPHONE #
		DATE