



# PHYSICAL FORM\*

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## MEDICAL RELEASE AUTHORIZATION

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

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

## PHYSICIAN'S STATEMENT

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

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Physician \_\_\_\_\_ Date of Physical \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Please include the following:**

- TB Skin Test Date Placed: \_\_\_\_\_ Date Read: \_\_\_\_\_ Results: \_\_\_\_\_
- CXR (if TB test positive) Date: \_\_\_\_\_ Results: \_\_\_\_\_ (Note: Must have copy of chest x-ray report.)
- Td Date: \_\_\_\_\_
- Tdap Date: \_\_\_\_\_ Results: \_\_\_\_\_ Immunity Present? \_\_\_\_\_
- Rubella Titer Date: \_\_\_\_\_ Results: \_\_\_\_\_ Immunity Present? \_\_\_\_\_
  - History of disease Date: \_\_\_\_\_
  - Immunization Date: \_\_\_\_\_
- Rubeolla Titer Date: \_\_\_\_\_ Results: \_\_\_\_\_ Immunity Present? \_\_\_\_\_
  - History of disease Date: \_\_\_\_\_
  - Immunization Date: \_\_\_\_\_
- Mumps Titer Date: \_\_\_\_\_ Results: \_\_\_\_\_ Immunity Present? \_\_\_\_\_
  - History of disease Date: \_\_\_\_\_
  - Immunization Date: \_\_\_\_\_
- Varicella Titer Date: \_\_\_\_\_ Results: \_\_\_\_\_ Immunity Present? \_\_\_\_\_
  - History of disease Date: \_\_\_\_\_
  - Immunization Date: \_\_\_\_\_
- Hep B Titer Date: \_\_\_\_\_ Results: \_\_\_\_\_ Immunity Present? \_\_\_\_\_
  - Series # Date: 1: \_\_\_\_\_ 2: \_\_\_\_\_ 3: \_\_\_\_\_
- Color Blindness Test Date: \_\_\_\_\_ Results: \_\_\_\_\_
- Fit Testing Date: \_\_\_\_\_ Results: \_\_\_\_\_

## I. Hepatitis B Vaccination Declination – Please complete Bloodborne Training before signing

I, \_\_\_\_\_, understand that, due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine. However, I decline Hepatitis B vaccination at this time. I understand that, by declining this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine and am employed by Advantage RN, I can receive the vaccination series.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

This is a regulatory requirement under 29 CFR 1910 1030. If you decline the vaccination and refuse to sign the Declination paragraph, your offer will be withdrawn or your assignment will be terminated.

## II. Hepatitis B Vaccination Acceptance – Please complete Bloodborne Training before signing

I, \_\_\_\_\_, choose to receive the Hepatitis B vaccine offered by Advantage RN in accordance with the OSHA Bloodborne Pathogen Standard 29CFR 1910 1030 (f)(2)(i). I understand that administration of the vaccine may cause side effects, and under certain conditions is not medically advised. I have consulted with a physician and have determined that it is appropriate for me to receive the vaccine based on my potential exposure.

I release Advantage RN and its employees from any liability in connection with the administration of the vaccine.

I understand that this procedure is a series of three shots. The second dose is to be administered 30 days after the initial dose, and the third dose is to be administered six months after the initial dose. All three shots are required to complete the vaccination process. If I am not employed by Advantage RN when the other shots are due, it will be my responsibility to see that they are completed. I also understand that the vaccine may lose its effectiveness over time and may require booster shots. These are also my responsibility if I am not employed by Advantage RN.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_