Physicians Statement

Applicant name: _____ SS#: _____

Tuberculosis Screening

	Date Given	Date Read	Results
PPD/ TB Skin Test			Induration _____ mm Negative Positive Circle One
Chest X-ray (if PPD +)*			

*Attach copy of the radiology report and a copy of the +PPD reading.

Immunization Status

Document date of vaccine/titre and results. Attach all Titre laboratory reports.

Vaccination	Vaccination Date	Results
Tetanus		
MMR Vaccine 1		
MMR Vaccine 2		
Hepatitis B Vaccine 1		
Hepatitis B Vaccine 2		
Hepatitis B Vaccine 3		
Varivax Vaccine		
Titres		
Titre	**Titre Date**	**Results**
Rubella Titre		___ Immune ___ Non-Immune
Rubeola Titre		___ Immune ___ Non-Immune
Mumps Titre		___ Immune ___ Non-Immune
Varicella Titre		___ Immune ___ Non-Immune
Hepatitis B Titre		___ Immune ___ Non-Immune

The above named patient has been examined by me and found to be in good physical and mental health, free of communicable disease, and able to function without physical limitations as a healthcare professional.

Physician's Signature **License Number** **Date of Exam**

Physician's Name **City/State** **Telephone**

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