



Physician's Statement

Medical Release Authorization: I, do hereby authorize, _____, to release to Onward Healthcare, its affiliates, and any of its Client hospitals or institutions any information acquired in my recent medical examination that is relevant to my employment.

Signature: _____ Date: _____ Social Security Number: ____ - ____ - ____

Printed Name: _____ Date of Birth: _____

Physician to Complete This Section:

TB Skin Test (Date): _____	Results: _____ MM
If required, 2nd Step TB Test (Date): _____	Results: _____ MM
Chest X-ray (if TB test positive) Date: _____	Results: _____
Rubella Titer Date: _____	Results: _____
Rubeola Titer Date: _____	Results: _____ (Exempt if born before 1957)
Mumps Titer Date: _____	Results: _____
Vaccination MMR Dates: 1. _____ 2. _____	
Varicella Titer Date: _____	Results: _____
History Date: _____	
Vaccine Date: _____	
Hepatitis B Titer Date: _____	Results: _____
Hepatitis B Series: Date: _____ Date: _____ Date: _____	
Tetanus Date: _____	

Please submit supporting documentation of immunization records and lab results.

I have examined the individual named above, and to the best of my knowledge, s/he is in good physical and mental health and free of any communicable diseases. Employee is fit for duty without restrictions including being capable of performing max-assist patient transfers, and able to function in his/her profession at full capacity. By signing below, I certify that the above information is valid.

Physician's Signature: _____ Date of Exam: _____

Physician's Printed Name: _____ Phone: _____

Address: _____



Hepatitis B Vaccination Consent

As an employee having occupational exposure to potentially infectious materials, you will have the right to receive the Hepatitis B vaccination series, free of cost to you. Please read the Hepatitis B Vaccination information sheet and complete this form by checking the box preceding the appropriate statement and signing, dating and indicating your Social Security Number at the bottom. Thank you!

Consent: As a healthcare professional having occupational exposure to blood or other potentially infectious materials, which includes the risk of acquiring Hepatitis B virus (HBV) infection, I have been informed about and offered the opportunity to receive the Hepatitis B vaccine (to be paid for by my current employer). I understand that I must have 3 doses to vaccine to develop immunity. However, as with any medical treatment, there is no guarantee that I will not experience any adverse side effect from the vaccine. I accept the offer at this time.

Declination (General): 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, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future, while actively working with Onward Healthcare, if I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive it at no charge to me.

Declination (Specific): I am declining the opportunity to receive the Hepatitis B vaccination series for the following reason: (please check one)

I have previously received the complete Hepatitis B vaccination series.

(Please complete the Vaccination Record information below)

Antibody testing has revealed I am immune to Hepatitis B.

Vaccination Date: _____

The vaccine is contraindicated for medical reason.

Describe: _____

Other, explain: _____

Vaccination Record

Dose	Date Vaccinated	Lot #	Expiration Date	Given By
Dose #1				
Dose #2				
Dose #3				

Employee Social Security

Date

Employee Signature

Employee Name (Print)



Latex Allergy Physician Release

I, _____, do not have any known latex allergies.

I, _____, hereby authorize Onward Healthcare to release any information relevant to my employment regarding my allergy.

Signature

Date

PHYSICIAN TO COMPLETE THIS SECTION. ALL ITEMS MUST BE ADDRESSED.

1. Type of allergy (**circle one**): Latex Powder

2. Exposure Limits (**circle one**): Direct Contact Environmental

Please check one below:

- Irritant Contact Dermatitis: An external agent directly damages the skin, such as sweating and chafing due to prolonged glove use. Usually manifested as dry, crusty lesions where areas are exposed to latex.
- Allergic Contact Dermatitis (type IV): Produces skin lesions or a crusty thickened appearance of the skin. The reaction usually appears some time after exposure, so sensitized individuals may not always associate it with latex gloves. The rash may persist for 7-10 days, and is usually limited to the area where the skin came into contact with the latex. This allergy may also include contact pruritus, erythema, vesicular lesions, eczema and contact urticaria.
- IgE-Medicated Hypersensitivity (type I): Immediate reactions within 30 minutes to 1 hour from exposure may affect the skin, upper respiratory tract, lower respiratory tract or gastrointestinal tract. Skin manifestations include flushing, swelling and contact urticaria. Other manifestations are runny eyes and nose, symptoms of asthma, especially expiratory wheezing, diarrhea and/or vomiting.

Accommodations: **Describe in detail all special accommodations that are needed.**

Limitations: _____

Physician's Statement

I have examined the individual named above, and to the best of my knowledge, he/she is able to function in his/her profession as a healthcare professional, with the above listed accommodations and limitations.

Printed Name of Physician

Date of Examination

Signature of Physician

Signature Date