



EMPLOYEE HEALTH RECORD

I authorize, _____ M.D./R.N., N.P., to release any and all information regarding this physical to Across America Med Staffing, Inc.

Date

Employee Signature

Physical Exam -- To be completed by Practitioner

Employee Name: _____
Print First, Middle and Last Name

The above named individual is suffering from no physical disability or medical condition that would restrict or preclude him or her from providing services as a healthcare provider. Furthermore, this individual is not suffering from any contagious diseases to include, but not limited to, tuberculosis.

Practitioner's Signature: _____ Date of Physical Exam: ____ / ____ / ____

Practitioner's Name: _____ License Number: _____
Please Print

Address: _____

City: _____ State: _____ Zip: _____

Phone: ____ - ____ - ____

Tuberculosis Screening

PPD Skin Test Placed

By: _____ Site: _____ Date: ____ / ____ / ____

PPD Skin Test Read

By: _____ Result: _____ mm Date: ____ / ____ / ____

Chest X-Ray* Negative Positive Date: ____ / ____ / ____

* Invalid without Radiology Report