PHYSICIAN'S STATEMENT

I hereby authorize DuraCareNY to use or disclose this information to its client facilities, which may be relevant in evaluating my qualifications for employment opportunities and related activities.

_____ _____

Applicant Signature Date

I certify that _____ is in good physical and mental health, free of any communicable diseases, and is able to physically perform the job functions without restrictions.

_____ _____

Patient's Date of Birth Patient's Social Security Number

_____ _____

Physician's Signature Date of Medical Examination

_____ _____

Physician's License Number Physician's Name

CLINIC STAMP:

(Please make sure to have this stamped by the clinic)

Clear Form

DuraCareNY
YOUR HEALTHCARE SOLUTIONS

TB TEST SCREENING/RESULTS

PATIENT: _____ DOB: _____

PPD Test ☐ QuantiFERON ☐

DATE TEST COMPLETED: _____ FOREARM: ☐ LEFT ☐ RIGHT

If PPD or Quantiferon is positive, chest x-ray completed?

Date of XRay: _____

RESULTS: ☐ **Negative** ☐ **Positive**

DATE READ: _____

READ BY: _____

Examiner Name: _____

Examiner Signature: _____ Date: _____

RESULTS MUST BE SENT TO

FAX# (718) 313-0460

Vaccination Attestation Form

ANNUAL FLU VACCINE

☐ I have been vaccinated for influenza this flu season. Date_____ (On file agency)

☐ I have a contraindication to receiving the influenza vaccine.

☐ I decline the influenza vaccine, and I understand that due to my occupational exposure, I may be at risk of acquiring influenza infection. In addition, I may spread influenza to my patients and other healthcare workers, and my family, even if I have no symptoms. This can result in serious infection, particularly in persons at high risk for influenza complications. Accordingly, I understand that for infection control purposes I will be required to wear a surgical mask (except in the main lobby or cafeteria) throughout the flu season.

_____

Signature

_____

Print Name

_____

Date of Attestation

_____

Agency Representative Signature

Clear Form