HEALTH SCREENING REPORT - FACILITY PERSONNEL

All personnel, including applicant, licensee or employed staff of Residential Care Facilities for the Elderly, Community Care or Child Care Facilities must demonstrate that their health condition allows them to perform the type of work required. This health appraisal is to be completed by or under the direction of a physician.

A health screening, by or under the direction of a physician must have been performed not more than one year prior to employment or within seven (7) days after employment.

FACILITY NAME: Eastlake Medical College

FACILITY ADDRESS:

PERSON'S NAME | AGE

POSITION TITLE: Student Nursing Assistant | TYPE OF FACILITY | WORK DAYS PER WEEK | WORK HOURS PER DAY

DUTY STATEMENT

TYPES OF PERSONS SERVED *(Check appropriate items)*

- ☐ Infants
- ☐ Adults
- ☐ Developmentally Disabled
- ☐ Physically Handicapped
- ☐ Children
- ☑ Elderly
- ☐ Mentally Disordered
- ☐ Drug/Alcohol Addiction
- ☐ Other *(specify)* _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT.

SIGNATURE OF APPLICANT/LICENSEE OR EMPLOYEE ▶ | ADDRESS | DATE

NOTE TO PHYSICIAN: *Personnel in Residential Care Facilities for the Elderly, Community Care or Child Care Facilities shall be free from communicable disease, and capable of performing assigned tasks. Please complete the following information on the above named person.*

EVALUATION OF GENERAL HEALTH

EVALUATION OF ABILITY TO PERFORM WORK DESCRIBED IN THE ABOVE DUTY STATEMENT

NOTE ANY HEALTH CONDITION THAT WOULD CREATE A HAZARD TO THE PERSON, CLIENTS, CHILDREN OR OTHER PERSONNEL

DATE OF T.B. TEST | ☐ POSITIVE ☐ NEGATIVE | ACTION TAKEN (IF POSITIVE)

DATE OF HEALTH SCREENING | NAME OF PHYSICIAN (PHYSICIAN'S STAMP) | DATE

HEALTH SCREENING BY: (ORIGINAL SIGNATURE) ▶ | **TELEPHONE #** | **DATE**