Advanced Staffing Associates

55 Whiting Street, Suite 1B, Plainville, CT 06062 / Tel: (860) 747-6406 / Fax: (860) 793-6044 / www.advstaff.net

PHYSICIAN STATEMENT

Our medical facilities require a physician's statement of good health. This form must be filled out completely with the appropriate physician signature and information included. Advanced Staffing Associates must receive this completed statement before you begin employment, however do not delay in sending your completed application documents while getting this form completed. This will allow us to begin processing your application while we are waiting to receive your medical information. We will accept an alternate physician statement, but only if all the following information is included. **Please remember to attach all copies of test results.**

Employee/Patient Name (Please Print): _____

Date of Examination: _____

I hereby authorize the undersigned physician to release any medical information relevant to employment to Advanced Staffing Associates. I also authorize Advanced Staffing Associates to release this statement to any of its clients that I may be assigned to.

Employee/Patient Signature: _____

MMR Date _____ Or the following titres:

Mumps Titre Date _____ Serologic evidence of immunity Immune _____ Not Immune _____

Rubella Titre Date _____ Serologic evidence of immunity Immune _____ Not Immune _____

Rubeola Titre Date _____ Serologic evidence of immunity Immune _____ Not Immune _____

Varicella Zoster (Chickenpox) Date _____ Serologic evidence of immunity Immune _____ Not Immune _____

Diphtheria/Tetanus Booster Date _____ Result _____

DTP Vaccine Date _____ Result _____

TB / PPD Skin Test Date Given _____ Date Observed _____ Results _____
OR
Chest X-Ray Date _____ Results _____
PPD: Current within one year. If positive history – need CXR report. Documentation of a TWO-STEP Mantoux (PPD) skin test or Blood test.

Hepatitis B Vaccine Date _____ #1 Date_____ #2 Date _____ #3
OR
Hepatitis Booster/Titre Date _____ Results _____
Hepatitis B – Immunization/titer. If refuse for any reason, need documentation.

Flu vaccination (or evidence of declination) Date: _____ Location: _____

I certify that I have performed a physical examination on the above mentioned individual and I further certify that this patient is in good physical and mental health, and is not suffering from any illness or physical or mental disability which would restrict him/her from providing services as a medical professional.

Physician's Name (Print) _____

Physician's Signature _____

Date _____

Telephone Number _____