24/7 Nurses
TWENTY-FOUR•SEVEN

Health Statement/ TB Questionnaire

(Employees/Applicants) Full Name: _____ Date of Evaluation: _____
(Please print clearly)

All of our employees must have an annual Health Statement completed by a physician or a nurse practitioner. Please return this to us as soon as possible.

Annual TB Questionnaire:

1. Chronic Cough	Yes	No	6. Hoarseness	Yes	No
2. Fever	Yes	No	7. Wheezing	Yes	No
3. Night Sweats	Yes	No	8. Shortness of Breath	Yes	No
4. Unexplained Weight Loss	Yes	No	9. Chest Pain (coughing up blood)	Yes	No
5. Hemoptysis	Yes	No			

If the employee has any of the above symptoms, and a Positive PPD, a chest X-ray is indicated.

Physical :

I have examined the individual named above and, to the best of my knowledge; he/she is in good physical and mental health, free of any communicable diseases, and able to function in his/her profession at full capacity. By signing below, I certify that the above information is valid.

_____ _____
Signature of Physician/ARNP *Date*

_____ _____
Printed Name of Physician/ARNP *Date of Physical*

_____
Physician/ARNP License Number ***(MUST BE COMPLETED)***

Fax form back to:
NJ: 973 689 2748 NY: 516-222-5514 or 800-630-6011