Medical Staffing Partners

Physician Statement

A Note of Importance:

Our medical facilities require a physician's statement of good health that is updated yearly. This form must be filled out completely with the appropriate physician signature and information included. We must receive this completed statement before you begin employment, however do not delay in sending your completed application while getting this form completed. 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 Medical Staffing Partners. I also authorize Medical Staffing Partners 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 _____ _____ Immune _____ Not Immune

Rubella Titre Date _____ _____ Immune _____ Not Immune

Rubeola Titre Date _____ _____ Immune _____ Not Immune

Measles – Vaccine after 1969 or titer. Exempt if born before 1957. No proof, revaccinate.
Rubella – Vaccine after 1970 or titer. Exempt if born before 1967 and > 55 years. Exception of <55 years and female, exempt if had a hysterectomy, TL, post-menopausal. No proof, revaccinate.

Varicella Zoster Date _____ _____ Immune _____ Not Immune

Varicella states disease or titer done. If working in pediatrics and no disease, need titer.

TB / PPD Skin Test Date _____ Results _____

OR

Chest X-Ray Date _____ Results _____

PPD: Current within one year. If positive history – need CXR report.

Hepatitis B Vaccine Date _____ #1 Date _____ #2 Date _____ #3

Hepatitis Booster Date _____

Hepatitis B – Immunization/titer. If refuse for any reason, need documentation.

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

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 registered nurse.

Physician's Name _____ Physician's Signature _____

Please Print

Telephone Number _____ Date _____

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651-407-0300

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651-407-8977