Employment Health Examination

J&A HEALTH SERVICES, LLC.

☐ Pre-Employment Physical Assessment	☐ Annual Assessment	☐ Return to Work/LOA	☐ Other

Demographic info:

Date:		Position(S) Applied For:	PA ☐, PCA ☐, HHA ☐, RN/LPN ☐, Clerical ☐, Other: _____						
Last Name:				First Name:					
Address:		Apt:		City:		State:	NY	Zip Code:	
Home Phone:		Mobile:		E-Mail:					
Marital Status:	M☐; S☐; W☐; D☐	Sex: M☐ F☐		Social Security:		DOB:			
HT:	**WT:**	**B/P:**	**Pulse:**	**Resp:**	**Temp:**				

To Be Completed by Examiner.

1. Physical Conditional and Review of Symptoms:		2. Experiencing any of the Following Symptoms?	
Head/Ent:		Weakness:	
Eyes:		Fatigue:	
Neck:		Lack of Appetite:	
Breasts:		Weight Loss:	
Lungs:		Low Grade Fever:	
Cardiovascular:		Night Sweat:	
Muscular Skeletal:		Flu Like Symptoms:	
Abdomen:		Chest Pain:	
Genitourinary:		Shortness of Breath:	
Neurological:		Persistent Cough:	
Comments:		Blood Streaked Sputum:	

**** Laboratory Test Results Must be Accompanied by Lab Reports****

T.B Skin PPD (Annually)	Date Implanted:		Date Read:		Results:	
If PPD is Positive	Chest X-Ray		Date:		Results:	
Rubella Titer:	Date:		Results:		Immune: ☐	Non Immune: ☐
Rubeola/Measles Titer:	Date:		Results:		Immune: ☐	Non Immune: ☐
Drug Screening:	Date:		Results:			
Comments By Examiner:						

Authorization to Release Information:

I hereby authorize _____ to Release all Health Information about me to J&A Health Services.

Employee Signature: _____

☐ This individual is free from any health impairment that is a potential risk to the patient or other employee of which may interfere with the performance of his/her duties including the habituation or addiction to drug or alcohol.

Physician Name:				Phone:	
Physician Signature:		License Number:		Date of Examination:	

****This Form Required Physician Stamp****

1222 Avenue M, Suite 201 Brooklyn, NY 11230; Office Phone: 718-872-6494 |Fax: 347-462-4073

J&A HEALTH SERVICES, LLC.

Annual Tuberculosis Screening Questionnaire

1. Do you currently have any of the following symptoms?

Symptoms:	Yes:	No:	Comments:
Weakness			
Fatigue			
Lack of Appetite			
Weight of Loss			
Low Grade Fever			
Night Sweats			
Flu Like Symptoms			
Chest Pain			
Shortness of Breath			
Persistent Cough			
Blood Streaked sputum			
Clear, Yellow or Dark Sputum			

2. Chest X-Ray: _____ Date: _____ Result: _____

3. Have you been exposed to anyone with the above signs or symptoms or who has had Tuberculosis: Yes: ___ No: ___

IF I SHOULD NOTICE ANY OF THE ABOVE SIGNS OR SYMPTOMS I WILL IMMEDIATELY NOTIFY MY PHYSICIAN AND SUPERVISOR OF MY AGENCY.

Employee Last Name _____Employee First Name: _____ ID: _____

Employee Signature: _____ Date: _____

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