HEALTH STATUS STATEMENT FORM

Notice to Applicant:
This physician's statement must be completed before you can begin any assignment with Maxim. Please **DO NOT** delay sending your completed application and other forms. This statement may be sent at a later date, but must be sent prior to the start of your employment.

APPLICANT INFORMATION: (Please Print)

Name: _____

Home Address: _____

City: _____ State: _____ Zip code: _____

TESTS PERFORMED: (Applicant must have TB skin test performed unless contraindicated by MD)

TB Skin Test: Date Performed ___/___/___* Date Read ___/___/___* Results_____

2nd Step TB Skin Test: Date Performed ___/___/___* Date Read ___/___/___* Results_____

TB skin test is contraindicated: Yes___ No___ (If yes refer to chest x-ray)

Chest X-Ray (if skin test, N/A): Date Performed ___/___/ ___*

Results/Evidence of tuberculosis?:_____

Reason chest x-ray performed:

____history of positive PPD _____allergy to serum ____ other (provide details) _____

- TB *test results must be current within a year of employment with Maxim Staffing Solutions.*
- Chest X-Ray results must be current within two years of employment with Maxim Staffing Solutions.

IMMUNIZATION RECORDS

Mumps Titer or Vaccine:	Date Performed: ___/___/ ____	Results: _____
Rubella Titer / or Vaccine:	Date Performed: ___/___/ ____	Results: _____
Rubeola Titer / or Vaccine:	Date Performed: ___/___/ ____	Results: _____
Varicella:	Date Performed: ___/___/ ____	Results: _____
Hepatitis Vaccine 1:	Date Performed: ___/___/ ____	Results: _____
Hepatitis Vaccine 2:	Date Performed: ___/___/ ____	Results: _____
Hepatitis Vaccine 3:	Date Performed: ___/___/ ____	Results: _____
Hepatitis Titer (if vac, N/A):	Date Performed: ___/___/ ____	Results: _____

HEIGHT/ WEIGHT (as applicable, per state licensing requirements):
Height: _____Weight: _____N/A:___

PHYSICIAN/ PRIMARY CARE PRACTITIONER'S STATEMENT:

I certify that the patient named above has been examined by me and found to be in good physical and mental health. Furthermore, they are free from communicable diseases and are able to perform the essential functions of the position for which he/she is applying.

Date of exam: ___/___/ ____

Additional Comments: _____

Name of Physician/Primary Care Practitioner (PCP): _____

License #:_____

Physician/PCP's Address: _____

City: _____ State: _____ Zip code: _____

Physician/PCP's Signature: _____Date: ___/___/ ____