HEALTH SCREENING REPORT - FACILITY PERSONNEL

All personnel, including applicant, licensee or employed staff of Residential Care Facilities for the Elderly, Community Care Facilities, Residential Care Facilities for the Chronically Ill, or Child Care Facilities must demonstrate that their health condition allows them to perform the type of work required. This health appraisal is to be completed by or under the direction of a physician.

A health screening, by or under the direction of a physician must have been performed within seven (7) days after employment or not more than six (6) months prior to employment for Residential Care Facilities for the Elderly, and not more than one (1) year prior to employment for Community Care Facilities, Residential Care Facilities for the Chronically Ill, or Child Care Facilities.

STAMP HERE (REQUIERED)

Facility Name
Facility Address

Person's Name		Age	
Position Title	Type of Facility	Workdays per Week	Work Hours per Day

Duty Statement

Observe and provide some assistance to on-site staff at the assigned healthcare facility. All visits and activities are performed under the direct and continuous supervision of authorized healthcare personnel.

TYPES OF PERSONS SERVED (Check appropriate items)

- ✔ Infants
- ✔ Adults
- ✔ Persons with Developmental Disabilities
- ✔ Persons with Physical Disabilities
- ✔ Children
- ✔ Elderly
- ✔ Persons with Mental Health Conditions
- ✔ Persons with Substance Use Disorder

Other (specify): _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT.

Signature of Applicant/Licensee or Employee	Address	Date

NOTE TO PHYSICIAN: Personnel in Residential Care Facilities for the Elderly, Community Care Facilities, Residential Care Facilities for the Chronically Ill, or Child Care Facilities shall be free from communicable disease, and capable of performing assigned tasks. Please complete the following information on the above-named person.

Evaluation of general health

Evaluation of ability to perform work described in the above duty statement

Note any health condition that would create a hazard to persons in care or other personnel

Date of T.B. Test	Positive Negative	Action Taken (If Positive)	
Date of Health Screening	Name of Physician (Physician's Stamp)		Date
Health Screening by: (Original Signature)		Telephone	Date