Annual Physical/Health Statement with TB Questionnaire

(*To be completed by a Physician, Nurse Practitioner or Physician Assistant. All dates must include day-month-year)*

Section A.

Name of Patient (Please Print):_____

Last 4 digits SSN: _____ Date of Physical Exam_____

Color Blind Exam (Please circle**):** **Pass Fail** (Required)

Section B.

Practitioners please complete this section ONLY if patient has a history of positive PPD or received the BCG vaccine:

Date of positive PPD skin test: _____ Date of last CXR: _____
Date of BCG vaccination, proof of vaccination may be required: _____

Please indicate if the patient is having any of the following symptoms for greater than 3 weeks:

1. Chronic Cough	Yes	No
2. Production of Sputum	Yes	No
3. Blood in Sputum	Yes	No
4. Unexplained Weight Loss	Yes	No
5. Fever/Chills	Yes	No
6. Fatigue/Tiredness	Yes	No
7. Night Sweats	Yes	No
8. Shortness of Breath	Yes	No

Section C.

The above mentioned person has been examined by me and to the best of my knowledge, he/she is in good physical and mental health, free from any prior injuries that may preclude him/her from being able to function and perform all job duties required of a healthcare professional without any physical limitations, free from any communicable diseases; and is able to function in his/her profession at full capacity with no limitations.

Printed Name ☐ ***MD*** ☐***PA*** ☐***NP*** ***Date***

Signature ***OFFICE STAMP or*** *address, phone and fax*

*** This document is subject to verification.**