PHYSICIAN'S STATEMENT

This form must be completed by a physician, physician assistant, or nurse practitioner.

Personal Data

Name _____ Social Security Number _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Mobile _____

Medical Release Authorization

I _____ do hereby authorized _____ to
Patient's Name *Physician's Name*

released anyinformation acquired during medical examination, relevant to employment with **Best of best HomeCare, Inc.**

Immunization Records

Best of Best HomeCare, Inc must receive a copy of the results of all vaccinations, and or chest x-ray reports (if applicable) before employee is hired for the purpose of home health staffing. Vaccination dates, not titers, are required for home health staffing only.

	Date	Results	Immune
Hepatitis Vaccine 1			
Hepatitis Vaccine 2			
Hepatitis Vaccine 3			
Polio Vaccine			
MMR Vaccine			
Diphtheria-Tetanus (DT) Vaccine *(required every 10 years)*			
T.B. Skin Test (PPD)		Neg. ☐ Pos. ☐	MM
Chest X-Ray (only if PPD pos.)			
BCG Vaccine *(vaccine given in foreign countries for TB, not given in USA)*		Neg. ☐ Pos. ☐	

Best of Best HomeCare, Inc.
5185 Ilchester Woods Way, Ellicott City, Maryland 21043 USA
1.888.380.7323 | info@bestofbesthomecare.com

PHYSICIAN'S STATEMENT

This form must be completed by a physician, physician assistant, or nurse practitioner.

Physical Examination

Temp _____ Pulse _____ Respirations _____ Blood Pressure _____

The above named patient has been examined by me and found to be in good physical and mental health, free of communicable disease and able to function without any physical limitations or weight lifting restrictions as a healthcare professional.

Physician Name (please print) _____ License Number _____

Physician Address _____

City/State/Zip Code _____ Phone _____

Physician Signature _____ Date _____

HEPATITIS B VACCINE

DECLINATION

_____ I understand that, due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infections. I have been given the opportunity to be vaccinated with hepatitis B vaccination at this time free of charge. I understand that, by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ I have elected to voluntarily be vaccinated with Hepatitis B vaccine offered by the agency. I have received vaccine information regarding risk associated with this vaccination.

_____ I have completed the Hepatitis B vaccination series.

Name of Employee (printed): _____

Signature: _____ Date: _____

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