

## Statement of Health

**All items on this authorization must be completed in full, or the request will not be honored.**

### Part A. Authorization

I acknowledge and understand that First Assist, Inc. (the "Company") and its clients require medical documentation reasonably necessary to make decisions regarding my employment with the Company and assignments to its clients. I agree to provide all medical documentation requested by the Company and to provide my physician with authorization to release requested documentation to the Company. I authorize the Company to share requested medical documentation with any First Assist client to which I am assigned or seek to be assigned.

I hereby authorize my physician, , to release information about my health to the Company including: latex allergies (if any); vaccination records and information regarding exposure to communicable diseases; and accommodations and limitations regarding my health. I understand that the information in my health record may include information relating to: sexually transmitted diseases; acquired immunodeficiency syndrome ("AIDS"); human immunodeficiency virus ("HIV"); behavioral or mental health services; and treatment for alcohol and/or drug use; and I consent to release of any such applicable information. If my physician has records from another provider, I wish to have those records released under this authorization.

I understand that:

- This authorization is voluntary.
- This authorization is effective immediately and will expire upon the termination of my employment with the Company.
- My treatment, payment for it and/or eligibility for enrollment or benefits cannot be conditioned on my signing this authorization form, although if I refuse to sign, I may not receive an offer of employment or be eligible for assignment by the Company.
- I may receive a copy of this form.
- I may inspect protected health information about me held by any provider without signing this form.
- This authorization to disclose information may be revoked by me at any time, except to the extent that action has been taken prior to receipt of my written revocation. To revoke the authorization, I understand that I must notify the Company in writing.
- Once information covered by this authorization has been disclosed, redisclosure of the information by that recipient is possible and the information may no longer be protected by federal privacy regulations but may be protected by state law.

Name:

Address:

Date of Birth:

Phone #:

Date:

Signed By \_\_\_\_\_

Part B. Health Statement

Having performed a physical examination on

(insert name of patient), I verify that the following are true and accurate:

1. The patient is suffering from no physical disability or contagious diseases that restrict him/her from providing services as a [job title].

Physician/Practitioner initials:

2. Please provide dates for the following, as applicable:

<u>Date(s) of Vaccination or Titer</u>	<u>Result</u>
TB Test by PPD	<input type="text"/>
TB Test by Chest X-Ray	<input type="text"/>
Hepatitis B Series	<input type="text"/>
Hepatitis B - Titer	<input type="text"/>
Hepatitis B - Waiver	<input type="text"/>
Rubeola Titer	<input type="text"/>
Mumps Titer	<input type="text"/>
Rubella Titer	<input type="text"/>
MMR Vaccine #1	<input type="text"/>
MMR Vaccine #2	<input type="text"/>
Varicella Titer	<input type="text"/>

If born after 1956, a 2nd MMR is required.

**Must have actual vaccination and/or titer records attached with this statement.**

3. Allergies (must check one):

None

Other (describe):

Powder (describe degree of sensitivity and symptoms):

Latex (describe degree of sensitivity and symptoms):

4. Accommodations/Limitations (describe in detail all accommodations and limitations to patient's job performance):

*I have examined and obtained a current history on the individual named above, and, to the best of my knowledge, he/she is in good physical and mental health, is free of any communicable diseases, has no physical limitations other than as described, and is able to function in his/her professional discipline and specialty on a full-time basis at full capacity, either without any accommodations or with the accommodations described above.*

Signature of Examining Practitioner

Date

Physician/Practitioner Name:

Address:

Telephone #: