Gracefully Meek Home Care LLC

319 S Main St

Chiefland, FL 32626

(352) 215-3179 / Fax: (352) 389-2690

Contractor Health Statement

Name:_____

Last Name First Name Middle Name

DOB:_____ Contractor Position: _____

To Be completed By Examiner

T/P/R: __ /__ /__ BP:__ /__ Date of Birth:__ /__ /__ Height:_____ Weight:_____

Review of Medical History Completed on:___ /__ /__ Physical Examination completed on __ /__ / __

Comments:_____

IF ANY OUTSTANDING IMMUNIZATION RESULTS ARE NOT CURRENTLY AVAILABLE, PLEASE FAX THEM TO (352) 389 -2690

Hepatitis B: **2 options:** **(One of the two columns to the right must be completed to meet requirements.)**		**3 Hep B with 2nd at least 4 weeks after 1st and 3rd at least 4 months after 1st: Give dates.** **__ /__ /__ , _/__ /__** **__ /__/__**	**1 positive titer:** **Give date:** **__/__/__**
Tetanus (Td/Tdap): **(Must be current through the entire length of the contract; due every 10 years.)**		**Tetanus booster:** **Give date:** **__ / __ /__**	
Tuberculosis (TB) is due annually: **3 options:** **One of the three columns to the right must be completed to meet requirements.)**	**Negative PPD (to be repeated annually):** **Give date:** **__/__/__**	**If positive PPD or positive QFT or T-Spot, provide a negative chest x-ray date.** **Give date:** **__ / __ /__**	**Negative interferon-gamma release assay (QFT or T-Spot)** **Blood test date:** __/__/__

I hereby certify that the person named above has been examined by me and found to be in good physical and mental health and is able to physically perform all work related duties and is free of signs and symptoms of communicable disease including TB, and does not constitute a risk of communicating disease to any person under the care of the agency.

MD/DO/PA/ARNP Signature (Required) Date (Required)

Official Office Stamp (Required)