HEALTH SCREENING REPORT

All personnel 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 six (6) months prior to employment or within 15 days after employment.	FACILITY NAME HOPE MEDIVAN FACILITY ADDRESS 1601 COFFEE RD, MODESTO, CA		
PERSON'S NAME		AGE	
POSITION TITLE	TYPE OF FACILITY MOBILE MEDICAL/DENTAL CLINIC	WORK DAYS PER WEEK	WORK HOURS PER DAY
DUTY STATEMENT			

TYPES OF PERSONS SERVED (Check appropriate items)

☐ Infants ☒ Adults ☐ Developmentally Disabled ☐ Physically Handicapped
☒ Children ☒ Elderly ☐ Mentally Disordered ☐ Drug/Alcohol Addiction
☐ 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 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 THE PERSON, CLIENTS, CHILDREN, OR OTHER PERSONNEL			
DATE OF TB TEST	☐ POSITIVE ☐ NEGATIVE	ACTION TAKEN (IF POSITIVE)	
DATE OF HEALTH SCREENING	NAME OF PHYSICIAN (PHYSICIAN STAMP)		DATE
HEALTH SCREENING BY (ORIGINAL SIGNATURE):		TELEPHONE	DATE