TRUECARE

# EMPLOYEE PHYSICAL FORM - TO BE COMPLETED BY PROVIDER

Name: Sex: Date of Exam:

DOB: Social Security Number:

## Physical Findings

| | | |
|---|---|---|
| Height: | Weight: | General Appearances: |
| Blood Pressure: | Pulse | Respiration: |
| Heart: | Lungs: | |
| G.I: | Musculoskeletal: | |
| Current Medications: | | |

## Test/Lab Results (** Test/Lab Results are only required upon hire**)

| | | | |
|---|---|---|---|
| **PPD (Mantoux) Results: | | | Attach Documentation |
| **PPD 2 (Mantoux) Results: | | | Attach Documentation |
| **Chest X-Ray if PPD Positive: Documentation | Date Read: | Results: | Attach |
| **Quantiferon TB Gold Test: Documentation | Date Given: | Results: | Attach |
| **MMR (Measles, Mumps, Rubella) Attach documentation - Lab Report | | | |
| 1. Proof of immunity with titers **OR** 2. Proof of 2 doses as proof of immunization | | | |
| **4 Panel Drug Screen Results Attach Documentation | | | |
| Influenza Vaccine: Date Administration: | Lot #: Expiration Date: | | |

Does this patient have any physical limitations: Yes: No:

If Yes, explain any limitations in detail:

**THIS PERSON IS FREE FROM ANY HEALTH IMPAIRMENT WHICH IS OF POTENTIAL RISK TO THE PATIENT OR WHICH MIGHT INTERFERE WITH THE PERFORMANCE OF HIS/ HER DUTIES, INCLUDING THE HABITUATION OR ADDICTION TO DEPRESSANTS, STIMULANTS, NARCOTICS, ALCOHOL OR OTHER DRUGS OR SUBSTANCES WHICH MAY ALTER THE INDIVIDUALS BEHAVIOR.**

Provider's Signature:

Provider's License Number: Date:

## MEDICAL STAMP

Please Note:

*This document must be stamped with p rovider's official stamp and be accompanied by the required documentation. The physical form will not be accepted without the proper verification.*

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# TB TESTING REQUIREMENTS

**Name:** _____

**SSN:** XXX-XX-_____ **DOB:** _____

**Accepted TB Tests**

- Two-step TST (Tuberculin Skin Test / PPD)
- IGRA — QuantiFERON-TB Gold
- IGRA — T-Spot

**Time Requirements**

- TST/IGRA result must not be older than **1 year**
- Chest X-ray acceptable if not older than **10 years**
- Chest X-ray must be accompanied by proof of a previous positive test

**What is IGRA/QuantiFERON?**

- A blood test that detects TB infection
- Does not require a follow-up visit like the skin test.
- Results in 24-48 hours at most labs.

| STAMP |
| --- |
| TRUECARE<br>117 CHURCH AVE<br>BROOKLYN, NY 11218<br>718-854-8783 |

**Employee Signature :** _____ **Date**:_____

Licensed Professional: _____

License#: _____

Date: _____

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# DRUG SCREENING REQUIREMENTS

**Name:** _____

**SSN:** XXX-XX-_____ **DOB:** _____

**Accepted Panel Types**

- 4 to 7-panel drug screen (or more) is acceptable
- Minimum of 4 panels — fewer will not be accepted
- All results must be **negative**

**Standard 4-Panel Screen Covers**

- THC (cannabis/marijuana)
- Cocaine
- Opiates
- Methamphetamine

**Positive Result Policy**
A doctor's note or valid prescription must be submitted to support any positive result
Results without documentation cannot be accepted

| STAMP |
| --- |
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**Employee Signature :** _____ **Date**:_____

Licensed Professional: _____

License#: _____

Date: _____

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# FLU VACCINE DECLINATION

Print Name _____ Date of Birth ____ / ____ / ____
Month Day Year

## I DO NOT WANT A FLU SHOT

I acknowledge that I am aware of the following facts:

- Some people with influenza have no symptoms, increasing the risk of transmission to others.
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months.
- I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.
- I have declined to receive the influenza vaccine for the 2025-2026 season. I acknowledge that the influenza vaccination is recommended by the Centers for Disease Control and Prevention for all healthcare workers in order to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.
- As per the Department of Health, if you choose **NOT** to be vaccinated you **MUST WEAR A MASK** whenever you are in the presence of a patient; mask's will be provided by the agency **ONLY** if you decline the vaccination.
- **My supervisor and manager, including division and departmental leadership will be notified that I declined.**

## I DECLINE VACCINATION for the following reason(s).

Please check all that apply. Reasons i do not wish to take the vaccine –

Please check all that apply.

- ⑤ I don't believe this vaccine is important.
- ⑤ I am concerned about side effects.
- ⑤ I never get the flu.
- ⑤ I have had a reaction to flu shots.
- ⑤ I don't like needles.

Knowing these facts, i choose to decline vaccination at this time.

I have read and fully understand the information on this declination form.

Print Name _____

Signature _____

Date ____ / ____ / ____
Month Day Year

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# Measles & Rubella Vaccines (MMR)

Provide proof of 2 MMR doses, or a blood test showing you are immune.
Bring your vaccination records or lab results to HR before your first shift.

**Name:** _____

**Employee ID:** _____ **DOB:** _____

**Start date:** _____ **Assigned location / Facility:** _____

## 2 MMR vaccine doses

I have documentation showing I received two doses of the MMR vaccine.

Dose 1 date (MM/DD/YYYY) _____

Dose 1 lot # (if known) _____

Dose 2 date (MM/DD/YYYY) _____

Dose 2 lot # (if known) _____

## Positive immunity blood test (titer)

A lab test confirmed I am immune to measles and rubella.

Lab test date (MM/DD/YYYY) _____

Testing lab / facility _____

Result (e.g. Immune — IgG positive for measles and rubella) _____

## DOCUMENTATION SUBMITTED — Check all that apply

- ☐ Vaccination record / immunization card
- ☐ Physician or clinic letter
- ☐ Lab report / titer results
- ☐ Other: _____

I confirm that the information and documentation I have provided are accurate and complete to the best of my knowledge. I understand that submitting false or falsified immunization records may be grounds for immediate termination and may be reported to the appropriate licensing authority.

**Employee Signature :** _____ **Date**: _____

Reviewed by: _____ Date: _____ Compliance status: _____