TRUECARE

ANNUAL SCREENING QUESTIONNAIRE

Name: _____

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

	Yes	No
Are you experiencing unresolved respiratory symptoms ?		
Are you coughing up blood ?		
Are you experiencing unexplained weight loss ?		
Are you experiencing increased sweating at night ?		
Serious illness, hospitalization or significant injuries in the past year?		
If yes, please specify:		
Have you visited any country **EXCEPT** Australia, New Zealand, Canada, U.S.A., Western Europe for **MORE** than one month?		
Are you currently, or have you been immunosuppressed in the past?		
Have you had close contact with someone with Tuberculosis?		

I certify that this information is correct and I understand that I am responsible to notify True Care if any of the above symptoms develop.

I understand that tuberculosis (TB) is a highly contagious respiratory disease and that mainly affects the lungs. The bacteria that causes TB are spread from person to person through tiny droplets released in the air by coughing or sneezing. Symptoms include those listed above. TB can be prevented by protecting myself from infected individuals with the appropriate personal protective equipment which would be provided to me by True Care. I will notify True Care if I have any symptoms of TB or if I am exposed to TB.

I also certify that I am not using, habituated, or addicted to depressants, stimulants, narcotics, alcohol or other drugs that may alter my behavior and that I am fully able to perform the duties of my job as required by True Care.

Caregiver / Employee Signature : _____
TodayDate:_____

[redacted]

Licensed Professional: _____

License#: _____

Date: _____

STAMP
TRUECARE 117 CHURCH AVE BROOKLYN, NY 11218 718-854-8783