MAS MEDICAL STAFFING
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Health Clearance Form

Date: _____
Patient Name:_____
Date of Physical Examination:_____

I attest that I have examined the above named patient and find he/she to be in good physical health, free of communicable diseases without pre-existing back injuries. He/She is free to work without any restrictions at this time.

Physician Signature:_____ Date:_____
Physician Name:_____
Address:_____
Telephone:_____

Immunization History

MMR vaccine #1_____ vaccine #2_____
Titer Date and Results_____

Tdap Date:vaccine_____

Varicella vaccine date_____ Titer date/results_____

Hepatitis B vaccine dates #1_____
#2_____
#3_____
Hepatitis B Titer Date and Results _____

Dates and results PPD #1_____ #2_____

Chest X Ray Date and Results
(if applicable) _____

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Reviewed 4/5/2010

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