



Nurse's Name (please print) _____

Date: _____ Height _____ Weight _____

Vital Signs: BP _____ HR _____ R _____ T _____

TB Screen: Date: _____ Negative _____ mm Positive _____

If Positive, Chest X-ray Date: _____

General Comments: _____

Please submit supporting documentation of immunization records and laboratory reports.

Immunization Record

| TYPE | DATE | RESULT |
|--------------------------------------|------|--------|
| TB/PPD Test | | |
| Chest X-Ray (if TB test if positive) | | |
| MMR | | |
| Rubella Titer | | |
| Rubeola Titer | | |
| Mumps Titer | | |
| Varicella Titer | | |
| Tetanus | | |

| TYPE | DATE | RESULT |
|--|------|--------|
| Hepatitis B Titer | | |
| Series | | |
| Hepatitis B Vaccine 1 | | |
| Hepatitis B Vaccine 2 | | |
| Hepatitis B Vaccine 3 | | |
| | | |
| Varivax | | |
| <small>(History of chicken pox is not acceptable unless w/ pos. titer)</small> | | |

If statement applies, the following information to be completed by a member of the **RN Recruit Staff**:

Hepatitis B Vaccination

OSHA requires all healthcare workers to be offered the Hepatitis B Vaccination by their employer.

I understand the OSHA guidelines and DECLINE the Hepatitis B Vaccination.

Signature: _____ Date: _____

I understand the OSHA guidelines and need # _____ or boosters in the series. I will make arrangements to complete the series or booster, or I will make arrangements with RN Recruit to receive this dose of the vaccine series. I will provide documentation of the series/booster to RN Recruit and provide appropriate updates.

Signature: _____ Date: _____

I certify that I have examined and obtained a current history on the individual named above; and to the best of my knowledge, he/she is in good physical and mental health, is free of any communicable diseases, has no physical limitations, that would interfere with the performance of his/her duties which may require: assistance with transfers; supporting patients during ambulation; providing personal care; light housekeeping; shopping; laundry and is able to function in his/her professional discipline and specialty on a full time basis at full capacity.

Physicians Signature: _____ Date: _____

Printed Name: _____ License Number: _____

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