AroundtheClock
HealthcareServices
"Staffing...whereverhealthcareisprovided."

HEALTH PROFILE

(To be Completed by Physician or Other Authorized Health Provider)

Name: _____ Date: _____

Social Security Number:_____

Latex Allergy: ☐ Yes ☐ No

MMR (Measles, Mumps, Rubella) Vaccine Date: _____

Mumps: _____ ☐ Proof of history ☐ Vaccine Date_____ Titer _____ ☐Pos ☐Neg

Rubella: _____ ☐ Proof of history ☐ Vaccine Date_____ Titer _____ ☐Pos ☐Neg

Rubeola: _____ ☐ Proof of history ☐ Vaccine Date_____ Titer _____ ☐Pos ☐Neg

Varicella: _____ ☐ Proof of history ☐Vaccine Date_____ Titer _____ ☐Pos ☐Neg

Hepatitis B Series_____ Dates:_____; _____; _____ Titer _____ ☐Pos ☐Neg

Hepatitis B Declination:_____

PPD/Mantoux Screen: _____ Date: _____ ☐ Satisfactory

TB Questionnaire (if applicable): Date: _____

Chest X-Ray: _____ Date: _____

General Comments:

_____

_____

I certify that the above person is free from symptoms indicating the presence of an infectious disease and does not have any restrictions which would interfere with the performance of his/her duties performed in the capacity of a _____.
Position

_____ _____ _____
Physician's Signature Authorized Health Provider's Signature Date

RELEASE: I authorize the release of the information contained on the front of this form to be provided to ATC Healthcare Services, Inc. only. I understand that this health profile is required in order that I may be considered for assignment with ATC Healthcare Services.

_____ _____
Signature Date

Revised: 2005

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