



WESTWAYS STAFFING SERVICES, INC.

Health Examination Form

Name: _____ Classification: _____

The following information is required by the TITLE XXH of the Health Code of the State of California for all persons working in acute care hospitals. In order to maintain compliance with the Laws of the State please provide Westways Staffing Services, Inc. with your physical prior to employment and ANNUALLY THEREAFTER.

PPD SKIN TEST:

Date given: _____ Date read: _____

Mm of induration: _____

Interpretation: negative positive

Signature of RN reading results: _____

Date: _____

CHEST X-RAY:

Date Taken: _____

Date Read: _____

Results: _____

PPD Positive Date: _____

RUBELLA:

Date Titers drawn: _____

Titer IGG results: _____

Status: immune not immune

Immunization date if not immune: _____

Date: _____

HEPATITIS B / IMMUNIZATION:

Hepatitis Vaccine:

1st dose _____

2nd dose _____

3rd dose _____

Or waiver signed: _____

MUMPS:

Date Titers drawn: _____

Titer IGG results: _____

Status: immune not immune

Immunization date if not immune: _____

Date: _____

HEPATITIS C / IMMUNIZATION

Date Titers drawn: _____

Titer IGG results: _____

Status: immune not immune

Immunization date if not immune: _____

Date: _____

RUBEOLA:

Date Titers drawn: _____

Titer IGG results: _____

Status: immune not immune

Immunization date if not immune: _____

Date: _____

TETANUS / DIPHTHERIA /ACELLULAR PERTUSSIS:

Date given: _____

Or WAIVER signed: _____

Notes: _____

Date: _____

VARICELLA:

Date Titers drawn: _____

Titer IGG results: _____

Status: immune not immune

Immunization date if not immune: _____

Date: _____

COLOR BLIND:

Date: _____

Results: _____

The above patient has been examined by me and found to be in good physical and mental health. There is no evidence of communicable disease and is able to carry out the functions as RN, LVN, LPT, CNA, or TECH without limitations.

Physician's Name

Physician's Signature

Date

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