Angels on Call
Someone to watch over you

126 Union Avenue
Peekskill, New York 10566
Telephone: 845-628-2255 Fax: 845-628-2258

Pre-Employement: ___
Other (specifiy):_____

Name: _____ Date of Physical: _____

Address: _____ D.O.B:_____ ☐ Male☐ Female

Phone: _____ E-mail Address: _____

HEIGHT: _____ WEIGHT: _____LBS. BP: _____

Do you Smoke? __ Y __N Do you drink alcoholic beverages? __Y __N

Do you take depressant, stimulant, narcotic drugs that alter your behavior? __Y __N
If yes, specify: _____

Do you take prescription medication? __Y __N
If yes, list medication names and what you take them for:_____
_____

Personal History: Please check all boxes that apply:

YES	NO	
		Rheumatic Fever
		Dysentery/ Parasites
		Tuberculosis
		Exposure to TB
		Diabetes
		Arthritis or Gout
		Back Problems
		Hepatitis

YES	NO	
		Heart Disease
		Hypertension
		Nervous Breakdown
		Pneumonia
		Convulsions
		Serious Injuries
		Fractures
		Chronic Disease

YES	NO	
		Ulcers
		Allergies
		German Measles
		Syphilis/ STD
		Substance Abuse
		Staph Infections
		Other:

☆ Two (2) PPD REQUIRED:

1st PPD (within one year of employment)

Date planted: _____ Planted by/title:_____ Site Planted_____
Date read: _____ Read by: _____ Results in mms: _____
Manufacturer:_____ Lot #:_____ Expiration date:_____

2nd PPD (within 30 days of employment)

Date planted: _____ Planted by/title:_____ Site Planted_____
Date read: _____ Read by: _____ Results in mms: _____
Manufacturer:_____ Lot #:_____ Expiration date:_____

☆ **Positive PPD:**

Date planted: _____ Planted by/title:_____ Site Planted_____
Date read: _____ Read by: _____ Results in mms: _____
Manufacturer:_____ Lot #:_____ Expiration date:_____

Chest X-Ray: Date: _____ Result: ☐ Negative ☐ Positive
(Full X-Ray Report must be attached)

☆☆OR☆☆

☆**Quantiferon/ TB Gold**: Date: _____ Result: ☐ Negative ☐ Positive
(Full Lab Report must be attached and dated within 90 days of hire date)

FOR PROFESSIONAL USE ONLY: The above named individual, with a history of a positive Mantoux and a negative Chest X-ray, is showing NO symptoms of Tuberculosis**.** ☐ **Yes** ☐ **No**

☆ Rubella Titre: Date: _____ Titre: _____ ☐ Immune ☐Not Immune
(Numerical value/lab result must be submitted)

☆ Rubeola Titre: Date:_____ Titre: _____ ☐ Immune ☐Not Immune
If born after 1/1/57 (Numerical value/lab result must be submitted)

☆☆OR☆☆

☆Rubella Vaccine: Date: _____

☆Rubeola Vaccine: Date: _____ (first) Date_____ (second)
If born after 1/1/57

Forensic Toxicology Drug Screen: Date_____ Result: ☐ Negative ☐ Positive
(**Full Lab Report must be attached and dated within 30 days of hire date**)

PHYSICAN'S COMMENTS:

After completion of the evaluation, my recommendation is:

☐ Acceptable for work without restrictions
☐ Acceptable to work the with restriction (e.g. lifting) Explain_____

I have examined the above named person and, to the best of my knowledge, have found him/her to be free from TB. Other communicable diseases or health condition including habituation or addiction to depressants, stimulants, narcotics, alcohol or other substances that may alter behavior which would be of potential risk to the patient, family or to employees or that may interfere with the performances of duties.

Physician Signature: _____ **Date: _____**

STAMP: **License #_____**