



Specializing in Healthcare Staffing Since 1995
6400 N. Andrews Ave., Suite 440, Ft. Lauderdale, FL 33309

Annual Employee Health & Pre-Employment Screen Form

Employee Name: _____ Date _____
SS#: _____

Ocean to Ocean Healthcare requires an annual tuberculosis test for each employee.

The tuberculin test is used to detect individuals with active or latent tuberculosis infections. A small amount of protein derived from the tuberculosis organism is injected into the skin. The test is read 48-72 hours later. Patients with active disease may not have any symptoms, but may be infectious to others. Active tuberculosis can be effectively treated. It is also important to identify individuals with latent infections. Preventive treatment can be given which will prevent the development of active disease and the subsequent infection of others.

Step I

If you have had a positive PPD in the past, or if you are allergic to purified derivative protein or eggs, go to Step II. If not, please complete Step I and provide a copy of your current TB test.

Form with fields for Date, Intradermal TB test, Mantoux type 5 tuberculin units of PPD, 0.1 cc SQ arm, Lot #, Exp. Date, Manufacturer, Given by, Reaction to Intradermal TB test, mm indurations, and Read by.

Step II

Since you have had a positive/sensitive PPD, you are required to have a chest x-ray. Chest x-rays must be completed every 5 years and a copy must be maintained in your file.

Date of last x-ray: _____ (please provide copy of x-ray results.)

Please read and put a checkmark in the correct space if you are experiencing any of the following symptoms or if any of the following apply to you:

- 1. Unplanned/Unexplained loss of weight (>10% of body weight)
2. Night sweats
3. Fever lasting several weeks
4. Frequent coughing in the absence of a cold or flu
5. Coughing blood-streaked sputum
6. Unusual tiredness or weakness lasting weeks
7. Pain in chest when taking a breath
8. Have you been recently diagnosed with diabetes, silicosis, HIV disease, Rental disease, liver disease?
9. Have you been recently been exposed to a family member or others with active TB?

If you checked YES to any of the above question, please explain condition and if you are being treated by a physician: _____



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If you develop any of the symptoms listed above, please contact your physician and us immediately. A chest x-ray must be performed prior to working again.

Please check the following statements that apply to you:

Varicella History

- I have had Chicken Pox.
I have NEVER had Chicken Pox.
I have not had Chicken Pox, but I may have cared for a person with Chicken Pox.
I have received the Varicella vaccine on date

Hepatitis B History

- I have been vaccinated for Hepatitis B and finished the series of 3 injections on date
I have started the series of 3 Hepatitis B injections, but did not finish the series.
I have had Hepatitis B in the past.
I refuse the Hepatitis B Vaccination Series.

Glove Sensitivity

- I have NO skin problems wearing gloves while performing my job duties.
I have skin problems wearing gloves while performing my job duties.

Please explain condition

Health Questionnaire:

Have you seen a physician for any illness or injury in the last 12 months? Yes No
Have you had any x-rays taken in the last 12 months? Yes No
Have you been hospitalized in the last 12 months? Yes No
Have you ever suffered a work related injury? Yes No
Have you ever filed for and/or received Worker's Compensation benefits? Yes No
Have you ever suffered an illness or injury other than at work where you were off from work for more than one week? Yes No
Have you ever been injured in a car accident? Yes No



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Please check any of the following activities for which you currently have or have had a restriction performing:

Lifting _____ Standing _____ Squatting _____
Carrying _____ Walking _____ Crawling _____
Sitting _____ Bending _____ Climbing _____

Give a brief description of any restrictions checked above.

N.M. STAT ANN. 52-1-28.3 (1991 W.C. ACT)

False statements and/or representations made on this questionnaire may cause forfeiture of worker's compensation benefits under the provision of 52-1-28.3 of the 1991 Worker's Compensation Act provided, the worker knowingly and willfully concealed information or made a false representation of his/her medical condition. Please note we require copies of all immunizations including TB, HEP. B & MMR (Measles, Mumps & Rubella) for our files.

This information listed above is true and correct to the best of my knowledge, and I understood all of the questions listed above.

Employee Signature

Date