BetterHealthcarePLLC

REPORT OF MEDICAL EXAMINATION

Patient Name:	I hereby authorize the release of information below to:
Patient Address:	Better Healthcare OT/PT, PLLC 10 Veschi Lane South, Mahopac, NY 10541 Tel: 914-373-6520 Fax: 914-373-6521 Employee Signature:

It is our company policy, in observance of State and Federal guidelines, to require a health statement for the protection of both our patients and healthcare providers. Please complete the following medical exam record regarding the individual named above, and returning it to us at your earliest convenience.

Patient Immunization Record

1. TB Screening: A. PPD / QFT: Date Injected: Date Reviewed: ☐ Positive ☐ Negative
   B. Chest X-ray (If PPD / QFT Positive): Date: ☐ Positive ☐ Negative
   C. Any New Symptoms: ☐ Yes ☐ No
2. Varicella (Chicken Pox) ☐ Positive (Result) / ☐ Negative Date
3. MMR 1 _____, MMR 2 _____ or MMR (IgG) Titre ☐ Positive (Result) / ☐ Negative Date:
   (Measles, Mumps, Rubella)
4. Date of Seasonal Influenza Vaccination: _____
5. Hepatitis B Vaccine (Optional) 1st dose_____ 2nd dose_____ 3rd dose _____ REFUSED___

Patient Physical Record

	Normal	Abnormal	COMMENTS
1. Head, Ear, Nose or Throat			
2. Respiratory			
3. Cardiovascular			
8. Musculoskeletal			
9. Skin			

Height	Respirations	Pulse	Blood Pressure	Temperature

Provider Information

He / She, name above was examined and found to be in good health and is free of any medical condition or infectious disease that may prevent his/her ability to perform services as a Health Care Worker (HCW). YES NO -- [Please circle either YES or NO.]

Medical Provider Address & Telephone (or Provider Stamp):

Physician Signature:	Date: