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Independent Healthcare Staffing, Inc

~ Of Nurses, For Nurses, By Nurses ~

PHYSICIAN'S STATEMENT

(Rev 1) 3/28/08

I have examined_____, and to the best of my knowledge, he/she is in good physical and mental health, free of any communicable diseases, and is able to function in his/her profession at full capacity.

_____ _____
Signature of Healthcare Provider Date

_____ _____
Printed Name of Healthcare Provider Date of Physical

Latex allergy ☐Yes ☐No If yes please explain_____

Vaccination Record

All Titers must be accompanied with Lab Results

Titers

Rubeola Titer Date _____ ☐Immune ☐Non-Immune Physician's Initials _____

Mumps Titer Date _____ ☐Immune ☐Non-Immune Physician's Initials _____

Rubella Titer Date _____ ☐Immune ☐Non-Immune Physician's Initials _____

Varicella Titer Date _____ ☐Immune ☐Non-Immune Physician's Initials _____

Hepatitis B Titer Date _____ ☐Responsive ☐Non-Responsive Physician's Initials _____

Immunizations

MMR Vaccination #1 Date_____ MMR Vaccination # 2 Date_____ Physician's Initials _____
(Second MMR Required if born after 1957)

Varivax Vaccination #1 Date _____ Varivax Vaccination #2 Date _____ Physician's Initials _____

Tetanus/Diphtheria Date_____ (10 Year) Physician's Initials _____

Hep B Vaccination #1 Date _____ Hep B Vaccination # 2 Date _____ Hep B Vaccination # 3 Date _____
Physician's Initials _____

Single Dose Vaccination

Mumps Date _____ Physician's Initials _____
Measles (Rubeola) Date _____ Physician's Initials _____
Rubella Date _____ Physician's Initials _____
MMR Date _____ Physician's Initials _____

By Signing and dating below, I certify that the information regarding immunizations and titers is valid. Otherwise not verified should be entered in the date field.

Physician's Signature Date