statement of good health

_____ _____ _____

provider name | provider signature | date

_____ _____

license number | address

I have examined the individual named below and 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. By signing above I certify that the information below is valid to the best of my knowledge.

applicant name: _____

Immunizations:

-hepatitis B titer or declination
-proof of MMR x 2 if you were born after 1957 and x 1 if you were born prior to 1957
-varivax is required to be eligible for employment if there is no supporting documentation for the varicella titer or history

Hepatitis B series	**MMR**	**Varivax**
date: _____	date: _____	date: _____
date: _____	date: _____	-OR- Varicella
date: _____		Immune by history of disease
		date: _____

TB skin test:

date: _____ results: _____ mm

-OR-

Chest x-ray (if TB positive):

date: _____ results: _____