

***Executive Search, Staffing and Consulting***

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*"Consciousness, Service, and Commitment to Excellence!"*

**2022 NETWORK ESC EMPLOYEE OCCUPATIONAL HEALTH PHYSICAL EXAMINATION FORM**

 **Request for Vital Signs**

Height in Feet:

Height in Inches:

Weight:

Body Mass Index: /CDC Interpretation: Blood Pressure:systolic

Blood Pressure: diastolic: Pulse:

Respiration:

Temperature: LMP Comments:

IMMUNIZATION DOCUMENTATION

First Name \_Last Name\_\_ \_ Date of Birth \_ \_ Employee

Department:

Job Title:

 MMB Vaccinations OR MMR TITERS

1st Vaccination *I* /\_ Date of Measles titer *I\_ I\_* Immune/ Not immune

2nc1 Vaccination *I I\_* Date of Mumps titer /\_ *I* Immune/ Not immune

Date of Rubella titer *I\_ I* Immune/ Not immune

|  |  |  |
| --- | --- | --- |
| Varicella VACCINATIONS | varicella Titer |  |
|  |  |  |

2nd Vaccination / /\_

Verbal History of illness: *(circle)* YES NO

Tdap\_(Tetanus diphtheria acellular pertussis) Date of vaccine / )

IUBERCULOSJS: 2 TUBERCU LIN SKIN TESTS OR 1 QUANTFERON GOLD TESTWITHIN PAST 12 MONTHS REQUIRED

Result *(circle}*

PPD # l \_ / / *\_ \_*

( mm) Negative Posi tive

PPD #2 / /

( mm) Negative Positive

Quantiferon TB Gold -Date /\_/ Negative Positive

*If History of positive PPD or Quantiferon date of most recent chest x-ray !\_\_/*\_ \_ Negative Positive.

BCG History? *(circle)* YES NO Please submit copy of report.

VISION SCREEN: OD (Right Eye):

 OS (Left Eye):

 OU (Both Eyes):

FINDINGS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COLOR VISION SCREEN:

FINDINGS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MASK FIT:

N-95 Qualitative Respirator Fit Test for Kimberly Clarke (PFR95) Halyard Fluid shield Level 3 N95.

Sensitivity Solution:

Sensitivity Test:

Respirator Type:

Respirator Size:

Fit test performed by:

Fit test results:

IMMUNIZATION CONSENT *I* DECLINATION

*CONSENT*

I have read or have had explained to me the information on the Vaccine Information Sheet. I have had a chance.

to ask questions which were answered to my satisfaction. I understand that due to my occupational exposure, whether by employment, residency, clerkship, or volunteering, I may be at risk of acquiring infection. I believe.

I understand the benefits and risks of the vaccine and request that the vaccine indicated below be given to me or to the person named below for whom I am authorized to make this request.

Patient or Legal Guardian Signature Relationship Date

Type of Vaccine: MMR (O.5ml subcutaneous)

#I Date'-- Manufacturer: Lot# Exp. Site \_

Diluent Lot # Diluent Exp. Date. .Provider ---- - - ----- VIS \_

#2 Date. \_\_ Manufacturer: \_ ,Lot# Exp. Site \_\_ Diluent Lot # \_\_Diluent Exp. Date.\_\_ .Provider \_ \_ VIS. \_ Type of Vaccine: Tdap *I* Td (O.5ml intramuscular)

Date .Manufacturer: Lot# Exp. Site ------

Provider \_ VIS Edition Date. \_

Type of Vaccine: Varicella (0.5ml subcutaneous)

#I Date. .Manufacturer: \_\_\_ \_.Lot# .Exp .Site \_ \_\_

Diluent Lot # \_.Diluent Exp.Date:\_ Provider ------------ VIS.\_ \_

#2 Date ,Manufacturer: .Lot# .Exp Site \_ Diluent Lot # .Diluent Exp. Date Provider ------------ VIS \_

*DECLINATION*

I understand the information provided and explained to me on the vaccine. I understand that due to my employment,

residency, clerkship, or volunteering, I may be at risk of acquiring infection. I have been given the opportunity to be vaccinated with the vaccine. However, I decline vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring a serious disease. If in the future I continue to have exposure to this infectious disease and want to be vaccinated, I can receive the vaccine at that time.

Type of Vaccine:*(circle)* MMR Varicella Tdap Td

Patient or Legal Guardian Signature Relationship Date

Reason for Declination: \_ \_ \_

HEPATITIS B Surface Antjbody and Surface Antigen. Hep B core Antigen

lst Dose *I I* 4th Dose *I I*

2nd Dose */ /*

5th Dose

 */ /\_\_*

3rd Dose */ /*

6th Dose

*/ /\_\_*

Titer Date */ /*

Titer Date *\_ /*

*/ \_\_*

Titer Result *(circle) Positive* Negative Titer Result *(circle) Positive* Negative

HEPATITIS B Panel

Hepatitis B Panel (that's the name that the test will fall under). Then include:

HBsAg (Hepatitis 8 surface antigen)- positive or negative Tither

anti-HBs or HBsAb (Hepatitis 8 surface antibody) - positive or negative Tither anti-HBc or HBcAb (Hepatitis 8 core antibody)- positive or negative

Titer Date------1------1--------

Titer Result *(circle) Positive* Negative

INFLUENZA VACCINE:

Titer Date *I\_*

Titer Result *(circle) Positive or* Negative

DATE:

*PHYSICIAN’S STATEMENT OF MEDICAL FITNESS FOR EMPLOYMENT*

On the basis of my findings, test results and details of the examination above,

1, , find that\_\_\_\_\_\_\_\_\_\_ is fit

to work with no restrictions.

Physician Signature: Date

Physician Stamp:

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