High Quality Care Nursing, Inc.

217 Main St. Laurel. MD 20707. Tel: 301-617-9315 Fax: 240-786-5382 Fax: 301-364-9119

Physician's Statement

This form must be completed by a physician, physician assistant, or nurse practitioner.

Personal Data

Name_____ Social Security Number_____

Address_____

City_____ State_____ Zip Code_____

Phone_____Cell_____

Medical Release Authorization

I _____ do hereby authorize_____ to
Patient Name *Physician Name*
release any information acquired during medical examination, relevant to employment with **High Quality Care Nursing Agency Inc.**

Immunization Records – High Quality Care Nursing Agency Inc. must receive a copy of the results of all vaccinations, and or chest x-ray reports (if applicable) before employee is hired for the purpose of home health staffing. Vaccination dates, not titers, are required for home health staffing only.

	Date	Results	Immune
Hepatitis Vaccine 1	_____		
Hepatitis Vaccine 2	_____		
Hepatitis Vaccine 3	_____		
Polio Vaccine	_____		
MMR Vaccine	_____		
Diphtheria-Tetanus (DT) Vaccine	_____ (*required every 10 years)*		
T.B. Skin Test (PPD)	_____	Neg.☐ Pos.☐	_____MM
Chest X-ray (only if PPD pos.)	_____		
BCG Vaccine	_____	Yes ☐ No ☐	

(vaccine given in foreign countries for TB, not given in USA)

Physical Examination

Temp _____ Pulse _____ Respirations _____ Blood Pressure _____

The above named patient has been examined by me and found to be in good physical and mental health, free of communicable disease and able to function without any physical limitations or weight lifting restrictions as a healthcare professional.

Physician Name (please print)_____ License Number_____

Physician Address_____

City/State/Zip Code_____ Phone_____

Physician Signature_____ Date_____

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HEPATITIS B VACCINE

DECLINATION

_____I understand that, due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infections. I have been given the opportunity to be vaccinated with hepatitis B vaccination at this time. I understand that, by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____I have elected to voluntarily be vaccinated with Hepatitis B vaccine offered by the agency. I have received vaccine information regarding risk associated with this vaccination.

_____I have completed the Hepatitis B vaccination series.

Name of Employee (printed): _____

Signature: _____ Date: _____