Premier Homecare

PROVIDER HEALTH CLEARANCE

A health form is required by the Department of Health and Mental Hygiene to determine that health/personal care workers do not pose health risk to clients, families or co-workers and the worker is in good health and able to perform all the duties of their job.

Please have this form completed by a licensed physician. The examinations must be current.

Applicant information (please print)

Name: _____
Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____
Date of Birth: ___/___/___ **Sex: Female**_____ **Male**_____
Home#:_____ **Mobile#:**_____

I have examined the above-named person and certify that he/she is:

- Free from communicable disease.
- Is in good physical and mental health, capable of doing physical household tasks and/or supervise and give care to adults. Also able to lift 170 lbs. or more without any restrictions which is required to perform the functions of their position as a caregiver.

Additional Information:_____

I hereby certify that I have examined the above named worker and the above is a complete and accurate assessment of my examination.

Physician (print name):_____

Address:_____ **City**_____ **State** _____**Zip Code**_____

Telephone#:_____ **Medical License#:**_____

Signature:_____ **Date:**_____

In addition to a general physical health examination, the following test(s) have been performed:

--Tuberculin test: (check one) PPD_____ Chest X-Ray_____ Other _____
Date:_____ Result:_____ Signature of recorder:_____

--Hepatitis B vaccines*Dates: Dose 1_____Dose 2_____Dose 3 _____

*If the healthcare worker elects **NOT** to take the Hepatitis B series they will need to fill out a waiver which will be provided by Premier Homecare.

PLEASE RETAIN A COPY FOR YOUR RECORDS

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