Metro 1 Home
Healthcare Service, Inc.
www.metro1homecare.com

301 BORDENTOWN AVE.
SUITE B 5 PARLIN, NJ 08859
Phone: 732-525-3600
Fax: 732-525-0001
Email: Metroservice34@aol.com

HEALTH ATTESTATION FORM

Employee Name: _____
Date of First Case: _____ (For supervisors, this is the first day worked.)

Action Completed	Date	Signature/Title
☐ Post-Offer Physical	_____	_____
☐ Rubella Screening	_____	_____
☐ Rubeola Screening (born in 1957 or later) Employee Birth Date: _____	_____	_____
☐ Initial TB Screening IGRA Blood Test OR	_____	_____
2-step Mantoux Screening	_____	_____
Or 2 Screenings in past 12 months	_____	_____
OR		
☐ Date of Chest X-Ray AND	_____	_____
☐ TB Questionnaire	_____	_____
☐ Annual TB Screening OR	_____	_____
☐ Annual TB Screening Questionnaire	_____	_____
	_____	_____
☐ Hepatitis B Vaccine: Date accepted/declined	_____	_____
☐ Periodic Physicals (if required by agency)	_____	_____

Designated Medical Reviewer

I attest that the above information is truthful and correct pursuant to my review of the health records.

Name (Print): _____ Title: _____
Signature: _____ Date: _____

Name (Print): _____ Title: _____
Signature: _____ Date: _____

Name (Print): _____ Title: _____
Signature: _____ Date: _____

Metro 1 Home
Healthcare Service, Inc.
www.metro1homecare.com

301 BORDENTOWN AVE.
SUITE B 5 PARLIN, NJ 08859
Phone: 732-525-3600
Fax: 732-525-0001
Email: Metroservice34@aol.com

ALTERNATE ASSESSMENT - TB SCREENING QUESTIONNAIRE

Employee Name: _____

This form is completed annually for those employees who have documentation of a negative Chest X-ray following a positive Mantoux screening test, and whose medical evaluation and Chest X-ray indicated that no further Mantoux screening is required.

Do you experience any of the following:	**Yes**	**No**
· bad cough that lasts longer than 2 weeks	☐	☐
· coughing up sputum (phlegm)	☐	☐
· coughing up blood	☐	☐
· loss of appetite	☐	☐
· weakness/fatigue/tiredness	☐	☐
· night sweats	☐	☐
· unexplained weight loss	☐	☐
· fever	☐	☐
· chills	☐	☐
· chest pain	☐	☐

Have you recently spent time with someone who has infectious tuberculosis? ☐ Yes ☐ No

Any other complaints? ☐ Yes ☐ No If yes, explain: _____
_____

The above health statements are accurate to the best of my knowledge. I have been inserviced on the signs and symptoms of tuberculosis and been advised to seek medical care if any of the symptoms develop at any time.

Employee Signature: _____ Date: _____

Nurse Reviewer Recommendation

☐ **Refer employee for medical evaluation immediately, before continuing work.**
☐ **No action to be taken at this time.**

RN Signature : _____ Date: _____

Metro 1 Home
Healthcare Service, Inc.
www.metro1homecare.com

301 BORDENTOWN AVE.
SUITE B 5 PARLIN, NJ 08859
Phone: 732-525-3600
Fax: 732-525-0001
Email: Metroservice34@aol.com

HEALTH STATEMENT

Applicant Name: _____ Date: _____

I ,_____ hereby attest that the state of my health is such that it will enable me to perform the duties of a health care professional. I further specifically attest that I am free of any and all potentially contagious diseases including, but not limited to those listed below:

AIDS	An htao	Chickenpox	Cholera
Diphtheria	Encephalitis	Hepatitis, Types A, B and C	Influenza
Leprosy (Hansen's Disease)	Leptospirosis	Malaria	Measles (Rubeola)
Meningitis	Mononucleosis	Mumps	Whooping Cough
Plague	Poliomyelitis	Psittacosis Ornithosis	Rabies
Rocky Mountain Spotted Fever	Rubella (German Measles)	Shigellosis	Smallpox
Tetanus	Tularemia	Tuberculosis	Typhoid Fever

Signature: _____ Date: _____

Metro 1 Home
Healthcare Service, Inc.
www.metro1homecare.com

301 BORDENTOWN AVE.
SUITE B 5 PARLIN, NJ 08859
Phone: 732-525-3600
Fax: 732-525-0001
Email: Metroservice34@aol.com

ON HIRE TB TARGETED MEDICAL QUESTIONNAIRE FORM

To be completed by employee:

_____
Print Name

	YES	NO
1. Have you ever had a positive TB skin test or history of TB infection? If the answer is YES, please answer the following:	___	___
2. Have you ever had the BCG vaccine?	___	___
3. Do you have prolonged or recurrent fever?	___	___
4. Have you recently lost weight?	___	___
5. Do you have a chronic cough?	___	___
6. Do you cough up blood?	___	___
7. Do you have sweating at night?	___	___

8. Do you have any of the following risk factors which may substantially Increase the risk of tuberculosis?

____ a. Silicosis (Lung Disease)
____ b. Gastrectomy
____ c. Intestinal Bypass
____ d. Weight 10% or more below ideal body weight?
____ e. Chronic Renal Disease
____ f. Diabetes Mellitus
____ g. Prolonged high-dose corticosteroid therapy or other Immunosuppresive therapy
____ h. Hematologic Disorder I.e. leukemia or lymphoma
____ i. Exposure to HIV or AIDS
____ j. Other malignancies

_____ _____
Employee Signature Date:

Metro 1 Home
Healthcare Service, Inc.
www.metro1homecare.com

301 BORDENTOWN AVE.
SUITE B 5 PARLIN, NJ 08859
Phone: 732-525-3600
Fax: 732-525-0001
Email: Metroservice34@aol.com

HEPATITIS VACCINE REQUIRMENT

I ,_____ acknowledge that I am at risk of exposure or have been unknowingly exposed to Hepatitis B as a result of my employment and acknowledge that the Agency will arrange for me to receive the Hepatitis vaccine at no cost to myself. It is my decision to:

☐ Request that I receive the Hepatitis vaccine

☐ Refuse the Hepatitis vaccine and HOLD HARMLESS THE AGENCY. I understand that by declining the 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 vaccine series at no charge to me.

☐ Provide written proof of immunity (attach)

☐ Provide written proof of previous vaccination (attach)

☐ Provide written proof of medical contraindication (attach)

Signature: _____ Date: _____