

# **Active Home Care Services LLC.**

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## **EMPLOYMENT RNA/LPN/CMT/GNA/ & CNA REQUIREMENTS**

**Name of Applicant:** \_\_\_\_\_

**You will need the following documentation:**

\_\_\_\_\_ **Unexpired – ID/Driver’s License, US Passport, Permanent Resident Card and Work Authorization Card**

\_\_\_\_\_ **Social Security Card (Original Only)**

\_\_\_\_\_ **Licenses**

\_\_\_\_\_ **2 References**

\_\_\_\_\_ **Pre-employment Physical (No later than 1 year of Application)**

\_\_\_\_\_ **Annual PPD Result (if positive, you must have Chest X-Ray Report)**

\_\_\_\_\_ **Void Check for Direct Deposit (MANDATORY)**

# REPORT OF TUBERCULOSIS SCREENING

DATE \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

## TO WHOM IT MAY CONCERN:

The above named individual has been evaluated by \_\_\_\_\_.  
(Name of health dept/facility)

\_\_\_\_\_ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

\_\_\_\_\_ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

\_\_\_\_\_ The individual either is currently receiving or has completed adequate medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

\_\_\_\_\_ The individual had a chest x-ray on \_\_\_\_\_ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

**Based on the available information, the individual can be considered free of tuberculosis in a communicable form.**

Signature \_\_\_\_\_  
(MD or Health Department Official)

Date \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_

**REPORT OF TUBERCULOSIS SCREENING**

**DATE** \_\_\_\_\_

**Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**TO WHOM IT MAY CONCERN:**

The above named individual has been evaluated by \_\_\_\_\_.  
(Name of health dept/facility)

***Tuberculin Skin Test (PPD)***

Date given \_\_\_\_\_ Date read \_\_\_\_\_

Results : \_\_\_\_\_ mm                      \_\_\_\_\_ Negative                      \_\_\_\_\_ Positive

***Chest X-ray Report – No active disease***

Date of Chest x-ray \_\_\_\_\_

\_\_\_\_\_ No evidence of active tuberculosis

The individual listed above has no symptoms or radiographic findings compatible with active tuberculosis. The individual is free of tuberculosis in a communicable form.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(MD or Health Department Official)

Address \_\_\_\_\_ Phone \_\_\_\_\_

***Chest X-ray Report – Abnormal Report***

Date of Chest x-ray \_\_\_\_\_

\_\_\_\_\_ Chest x-ray abnormal, active tuberculosis to be ruled out

Active tuberculosis cannot be ruled out in the individual listed above. The individual should be referred to a physician or health department for further evaluation.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(MD or Health Department Official)

Address \_\_\_\_\_ Phone \_\_\_\_\_

# HBV VACCINE / WAIVER FORM

Employee Name: \_\_\_\_\_ Date of Hire: \_\_\_\_\_  
*Print Name*

Social Security Number: \_\_\_\_\_

I understand that due to my occupational exposure to blood or other potential infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) Infection. **I have been given the opportunity to be vaccinated with Hepatitis B Vaccine, at no charge to myself.** 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 been advised of my rights to accept or decline the HBV Vaccine. HBV (Hepatitis B Virus) has been fully explained to me.**

\_\_\_\_\_ **I choose to waive my rights to receive the HBV Vaccine**

\_\_\_\_\_ **I choose to receive the HBV Vaccine and I understand that the vaccine is given in a 3-part series.**

Series # 1 Date	Series # 2 Date	Series # 3 Date

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Agency Rep. Signature*

\_\_\_\_\_  
*Date*

# Active Home Care Services LLC

## Physical Examination Form

To be filled by the Physician

**Employee information:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Allergies: \_\_\_\_\_

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**Medical Information:**

I have examined the above person; he/she is in sound health to perform the duty of patient care provider.

- Does not have signs and symptoms of communicable disease such as tuberculosis.
- Does not have physical disability or any form of handicap, that could impact his/her ability to perform patient care services
- Does not have any chronic conditions that will affect his / her ability to work as patient care provider.

**Recommendations:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physician Signature:** \_\_\_\_\_

**Physician Name:** \_\_\_\_\_

Office Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_