



## HEALTH CERTIFICATION FORM

Please photocopy completed form for your future use.

**Nurse Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

*The following information is required by TITLE XXII, of the Health Code of the State of California, for all personnel working in Acute Care Hospitals. In order that we maintain compliance with the Laws of the State, please provide Premier Nursing Services, Inc. with the results of the following tests prior to employment (ANNUALLY THEREAFTER for section A & H).*

<b>A. TUBERCULOSIS MANTOUX TEST (Must be read by RN, ARNP, PA or MD) (Required annually)</b>			
<input type="checkbox"/> PPD (Mantoux) -- tine or monovac not acceptable	Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	Date: _____	
<input type="checkbox"/> Positive PPD – Chest x-ray required (Valid for 2 years)	Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	Date: _____	
<input type="checkbox"/> Had BCG Vaccine -- Chest x-ray required if PPD not done	Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	Date: _____	
<input type="checkbox"/> Positive chest x-ray Treatment under Dr.	Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	Date: _____	
<b>B. RUBELLA (must be documented by positive titer or date of vaccination)</b>			
<input type="checkbox"/> Titer - Results	Date: _____	<input type="checkbox"/> Vaccine	Date: _____
<b>C. RUBEOLA (MEASLES)</b>			
<input type="checkbox"/> Titer - Results	Date: _____	<input type="checkbox"/> Vaccine	Date: _____
<b>D. MUMPS</b>			
<input type="checkbox"/> Titer - Results	Date: _____	<input type="checkbox"/> Vaccine	Date: _____
<b>E. VARICELLA (CHICKEN POX)</b>			
<input type="checkbox"/> Positive Antibody Titer	Date: _____	<input type="checkbox"/> Vaccine	Date: _____
<b>F. HEPATITIS B : <input type="checkbox"/> Has report of Immune titer</b> Date: _____			
<input type="checkbox"/> Completed vaccination series	Date: (Dose 1) _____	Date: (Dose 2) _____	Date: (Dose 3) _____
<b>G. HEPATITIS C : <input type="checkbox"/> Has report of titer <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive</b> Date: _____			
<b>H. Snellen Exam (Eye Exam)</b>	Date: _____		
<b>I. Diphtheria/Tetanus Booster</b>	Date: _____		
<b>J. DRUG SCREENING (12 Panel Recommended) <i>Please attach results of the test</i></b>			
<input type="checkbox"/> Completed	Date: _____	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive
<b>K. PHYSICAL EXAMINATION (Required annually)</b> Date: _____			
<b><i>The above named patient has been examined by me and found to be in good physical and mental health, without evidence of communicable disease and is able to carry out the functions and duties as a Healthcare Provider WITHOUT LIMITATIONS.</i></b>			

**Examining Physician's Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Address** \_\_\_\_\_

**Telephone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_**

**Return to:**  
Premier Nursing Service  
444 W. Ocean Blvd. Suite #1050  
Long Beach, CA 90802

**Phone:** (562) 437-4313  
**Fax:** (562) 495-1508  
**E-Mail:** info@premiernursing.com  
**Web:** www.premiernursing.com