ACCS

AMERICAN CRITICAL CARE SERVICES

JCAHO Accredited
Richmond

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____________________

Medical Release Authorization

I ____________________ do hereby authorize ____________________ to release
Patient Name *Physician Name*
any information acquired during medical examination, relevant to employment, to American Critical Care Services, and also to any of its client facilities.

Immunization Records – **ACCS must receive a copy of the results of all titers, vaccinations, and or chest x-ray reports (if applicable) before employee is hired.**

	Date	Results	Immune
Hepatitis Vaccine 1	______		
Hepatitis Vaccine 2	______		
Hepatitis Vaccine 3	______		
Hepatitis Titer	______	______	Yes No
MMR Vaccine	______		
Mumps Titer			
Rubella Titer	______	______	Yes No
Rubeola Titer	______	______	Yes No
Varicella Titer	______	______	Yes No
Tetanus Booster	______	(required every 10 years)	
T.B. Skin Test (PPD)	______	Neg Pos.	______MM
Chest Xray (only if PPD pos.)	______		
BCG Vaccine	______	Yes No (vaccine given in foreign countries for TB, not given in USA)	

Additional testing may be required for employment at some facilities.

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.

Name of Physician (please print)____________________ **License Number**____________________
Physician Address____________________
City/State/Zip Code____________________ **Telephone Number**____________________
Physician Signature____________________ **Date**____________________

ANNUAL TB REVIEW/FOLLOW UP

Please complete if history of positive PPD and chest x-ray results are over one (1) year old.

Employee Name: ______________________________ Date: ____________________

PPD Date: _________________

CXR Date: _________________

Does the employee have any of the following high-risk conditions:

HIV infection?	Infected with TB within last 2 years?	Diabetes Mellitus?
Elderly?	Any disease that weakens the immune system?	CA of head/neck?
Silicosis?	Lukemia or Hodgkins Disease?	Severe kidney disease?
Low body weight?	Corticosteroid treatment?	Organ transplants?

Did you take any preventative therapy?
NO ________ YES _______, Name of drug/Dates: ____________________________

Have you had any of the following?

	YES	NO
Bad cough that lasts longer than 2 weeks	_______	_______
Pain in the chest	_______	_______
Coughing up blood or sputum	_______	_______
Weakness or fatigue	_______	_______
Weight loss	_______	_______
Decreased appetite	_______	_______
Fever, chills, sweating at night	_______	_______

COMPLETED BY: ____
SIGNATURE/DATE

HEPATITIS B VACCINATION, CONSENT, AND DECLINATION

I. Acceptance of Hepatitis B Vaccine

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

Employee ______________________ Date ______________________

II. Declination of Hepatitis B Vaccine

I am refusing the Hepatitis B Vaccine and hold harmless the Agency. 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) infection. I have been given the opportunity to be vaccinated with Hepatitis B Vaccination.

However, I decline 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 want to be vaccinated with the Hepatitis B Vaccine, I may receive the Hepatitis B Vaccination Series at no charge to me from American Critical Care Services.

Employee ______________________ Date ______________________

III. Documentation of Hepatitis B Vaccine Series

If you have received the complete Hepatitis B Vaccine Series, you must attach to this form the documentation, which proves your receipt of the HBV Series and the titer results indicating your immunity. If you are unable to receive the vaccination series for medical reasons please attach supporting documentation.