

Authorization for Release of Confidential Information (to be signed by applicant):

I authorize the medical practitioner named below to release pertinent information from my recent physical relevant to my application for employment with Shore Staffing Inc.

Name of Applicant (please print) Signature Date

Physical Exam & Authorization to work: This form must be completed by Physician, NP or PA I have examined the individual named above and he/she is in good physical and mental health, free of any communicable disease and should be able to perform their responsibilities as a health care provider without limitation. They are in good health.

Physician/NP/PA---Please print your name Address of Practice

Physician/NP/PA Signature Phone number Date

PPD or Chest-X-ray Date given Date expired

Given by whom: Results:

PROOF OF HISTORY – VACCINE OR TITER – Attach proof of vaccination of titer

RUBEOLA Immunization Date (or) Titer Results
MUMPS Immunization Date (or) Titer Results
RUBELLA Immunization Date (or) Titer Results
VARICELLA Hx/TITER General Comments:
PHYSICIAN SIGNATURE: Date:

Hepatitis B Dates or Declination

I have received the series of three vaccinations for Hepatitis-B as listed below (attach documentation):

- 1. Date of First Injection
2. Date of Second Injection
3. Date of Third Injection

Employee Name: Date:

OR I have not received the series of three vaccinations and I understand that due to my occupational exposure to blood or other potentially materials, I may be at risk of acquiring Hepatitis B infection. At this time, I decline the Hepatitis B Vaccination.

Employee Name: Date:

Shore Staffing ANNUAL PHYSICAL FORM

EMPLOYEE NAME: _____

(By signing this form, I do authorize Shore Staffing to receive and release the following information acquired in my recent medical examination, which is relevant to my employment.)

PLEASE list any communicable disease you have had:

- 1.
- 2.

PROOF OF HISTORY – VACCINE OR TITER – Attach proof of vaccination of titer

RUBEOLA Immunization Date _____ (or) Titer Results _____

MUMPS Immunization Date _____ (or) Titer Results _____

RUBELLA Immunization Date _____ (or) Titer Results _____

VARICELLA Hx/TITER _____ General Comments: _____

PHYSICIAN SIGNATURE: _____ Date: _____

Hepatitis B Dates and Declination

I have received the series of three vaccinations for Hepatitis-B as listed below (attach documentation):

1. Date of First Injection _____
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Employee Name: _____ Date: _____

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Employee Name: _____ Date: _____