



Medical Release

I, _____ (Print Name) do hereby authorize _____ (Physician's Name) to release to RN Exclusive and any of its client hospitals or institutions any information acquired in my recent medical examination which is relevant to my employment.

Signed: _____ Date: _____

Tuberculosis Assessment (attach results)

TB Screen/PPD Date _____ Positive Negative
BCG Immunization Yes No Date: _____
(Chest X-Ray if positive) Date: _____
Have you ever been treated with preventative TB medication? Yes No

Check the symptoms listed below that you have experienced in the past year or currently have:

- persistent cough for more than 2 weeks
- Night sweats
- Anorexia (loss of appetite)
- Fever
- Unexplained weight loss
- Bloody sputum
- none of the above

PPD skin test is required annually by On-Call Staff Inc. Chest X-Ray is only accepted with proof of a positive PPD skin test.

PHYSICIAN'S STATEMENT

Does this client have any latex allergies? Yes No

I have examined the individual named above, and to the best of my knowledge, he/she is in good physical and mental health, free of any communicable diseases, and is able to perform in his/her profession at full capacity.

Comments: _____

Physician Signature: _____ Date: _____

Physician's Name: _____ License No. _____
(please print)

Office Address: _____

City: _____ State: _____ Zip: _____

Office Telephone Number: _____ Fax: _____