Health Form

CarePlus Home Health, Inc. employs Registered Nurses, Licensed Practical Nurses and Certified Nursing Assistants to provide direct care to clients. Employees will be in close contact with clients with various illnesses and disabilities in a home environment. Employees will work from a plan of care approved by the client's Health Care Provider that may include lifting and /or turning, etc. in the course of providing client care. This Physical Examination Form must be completed by the examining Physician/Nurse Practitioner.

Please return completed forms to:

CarePlus Home Health, Inc.
19390 Montgomery Village Ave
Montgomery Village, MD 20886
Tel: 301-740-8870
Fax: 301-740-8871

_____	_____	_____
Employee Name	Employee Signature	Date

TO BE COMPLETED BY EXAMINING HEALTH PROVIDER

Date Seen _____

Code: [WNL] = Within Normal Limits [R] = See Remarks

Allergies		Ears, Nose, Throat	
Height		Head/Neck	
Weight		Cardiac/Lungs	
BP/Pulse/Resp.		Abdomen	

If any history of joint injury/disease, describe in remarks below:

Back/Scoliosis		Remarks
Extremities		
Neurological		
Mental Health		

I have examined _____ and have determined that he/she ____(is) ____ (is not) free of communicable diseases and ____(is) ____ (is not) capable of performing direct care to clients serviced by CarePlus Home Health, Inc.

Examining Provider's Name _____

Examining Provider's Signature _____

Address _____

Telephone No. _____

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Health Form

PPD/HEPATITIS B FORM

CarePlus Home Health, Inc. requires all employees to submit to an annual TB testing or to be cleared through an annual health screening. It is also recommended that all clinical employees receive the Hepatitis B vaccination.

This form must be completed by your health provider and returned to CarePlus before placement and as a condition of continued employment.

If you have any questions, you may contact our office at 301.740.8870.

_____ _____ _____
Print Name Signature Date

TO BE COMPLETED BY EXAMING HEALTH PROVIDER

Provider Name _____

Office Address _____

_____

Telephone No. _____

TUBERCULIN TESTING

Type of Test: MANTOUX_____ INJECTOR_____

Lot# _____ Exp. Date _____

Tested By _____ Date Tested: _____

Results (In mm) _____ Read By: _____ Date Read _____

Which tests were done to verify the individual is free from active TB?

☐ PPD ☐ Chest X-RAY

Date _____ Result _____

HEPATITIS B

☐ Vaccination:

#1 _____ #2 _____ #3 _____

Date Date Date

☐ Declined by Employee _____

Employee Signature

Provider Signature _____ Title _____ Date_____

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