

**On-Call Healthcare Inc.**  
TELE/FAX 972-588-8008

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**Comprehensive Health Statement**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Please check all that apply:

- The above individual has been examined and found to be in Good health without evidence of communicable disease.
- Has no medical condition that would be aggravated or interfere with the use of respiratory protection.
- Should not be required to wear Respiratory Protection.

Physician or Nurse Practitioner:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

TB (Mantoux) Test: Date: \_\_\_\_\_ Results: \_\_\_\_\_

If unable to undergo a TB Test due to a past positive TB Test, a Chest X-Ray is acceptable. Please complete Annual TB Questionnaire form and submit to the nurse agency office.

Date: \_\_\_\_\_ Chest X-Ray Results: \_\_\_\_\_

Physician or Nurse Practitioner:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_