Therapeutic Resources
Staffing the U.S. with Rehab Professionals
www.therapeuticresources.org
Phone: 541-389-7499
Fax: 888-394-2351

IMMUNIZATION RECORDS

Employees must attach signed immunization records or lab evidence of immunity (titers). Depending upon the specific requirements of your hiring Clinic, MMR and Varicella may not be required. Please inquire with your recruiter to determine if these immunizations will be required for your assignment.

1. Hepatitis B – May sign declination below if no records or titers
2. Measles, Mumps, Rubella (MMR)
3. Varicella

HEP B: Have you ever received the Hepatitis B Vaccine?

_____ Yes, I have already received the vaccination series and have proof of immunity to Hepatitis B. Please sign below and provide documentation.

_____ No, I have not received the vaccination series and I decline to accept it at this time. In understand that due to the risk of occupational exposure to blood or other potentially infectious materials in my job, I may be at risk of acquiring hepatitis B virus infection. I understand that by declining this vaccine, I continue to have occupational exposure to blood or other potentially infectious material and, if at anytime, I want to be vaccinated with Hepatitis B Vaccine, I can receive the vaccination series at no charge. Please sign below.

I certify the above answers given by me are correct to the best of my knowledge.

Signature _____ Date:_____

TUBERCULOSIS SCREENING (PPD TEST)

Annual PPD Screening is required and documentation must be attached. Some assignments require two PPD tests in the last year, or a 2-step PPD. Check with your recruiter to determine the exact requirements for your assignment.

If you have a positive PPD, then evidence of a negative chest X-ray within the past two years must be attached.

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Physician Statement of Health

I,_____ , do hereby authorize_____

CLIENT NAME *PHYSICIAN NAME*

to release any information acquired during my medical examination to Therapeutic Resources. I also authorize Therapeutic Resources to release any information on this statement, relevant to employment, to any of its client facilities.

CLIENT SIGNATURE ***DATE***

Does this client have any latex allergies: Yes No

I have examined the patient and determined that this person is in good physical and mental health, has no signs or symptoms of communicable diseases, and is able to function and perform all job duties without any physical limitations in his/her profession at full capacity.

MD, DO, NP, PA, CNM

_____***SIGNATURE*** ***TITLE OF PROVIDER*** *(PLEASE CIRCLE)*

_____***PRINTED NAME*** _____ ***LICENSE NUMBER***_____***DATE***

OFFICE ADDRESS:

*Street:*_____

*City*_____ *State*_____ *Zip*_____

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Release of Health Information

I _____, an employee with Therapeutic Resources, Inc. Give

permission to _____ (Clinic) to fax results of the

following tests:

1. PPD
2. Drug Screen
3. Statement of Physical Health
4. Proof of Immunization titers

To Therapeutic Resources, Inc. at their secure fax number: 888-394-2351.

_____

Signature Date:

_____

Printed Name