



**P.O. Box 1334/401 Washington St., Cambridge, MD 21613 (O) 443-225-5887/(F) 443-225-5892**

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## **PHYSICIAN'S STATEMENT**

### **Employee Information:**

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

**Date:** \_\_\_\_\_

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

**Social Security Number:** \_\_\_\_\_

**I have examined the above individual and found them to be in good physical and mental health. Furthermore, this individual appears to be free of communicable diseases and is able to function as a Health Care worker without restrictions.**

**Physician's Name:** \_\_\_\_\_

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

**Phone #:** \_\_\_\_\_

**Physician's Signature and Date:** \_\_\_\_\_

**Notes:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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## TUBERCULIN TEST

### Employee Information:

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

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

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

Social Security Number: \_\_\_\_\_

**\*\*\* FOR PPD, PLEASE INDICATE "MM'S OF INDURATION."\*\*\***

**A "NEGATIVE" RESULT IS NOT ACCEPTABLE.**

### Expiration Date

Chest X-Ray or PPD / Montoux

Date

Result

\_\_\_\_\_

Physician's Name: \_\_\_\_\_

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

Phone #: \_\_\_\_\_

Physician's Signature and Date: \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_