Level One Personnel, Inc.

Health Statement/Release and TB Information

Worker - Please Complete This Section			
Name:		**Position/Discipline:**	
Address:		**Phone:**	

I authorize release of any information acquired in my recent medical examination which is relevant to my position with Level One Personnel (LOP) and its clients.

Worker Signature:	**Date:**

Allergies pertinent to the job (i.e. latex allergy): ☐ **No** ☐ **Yes/Explain:**___________________________________

(If answered yes to latex allergy - worker please complete and submit *Latex Allergy Questionnaire* to your LOP Representative)

Annual TB Information - Facility supplied documentation of TB Screen is also acceptable

Annual TB Screen (PPD):

Date Placed:______________________ Site: ☐ Right Forearm ☐ Left Forearm

Manufacturer:______________________ Lot #:__________ Exp. Date:______________

Placed By: ______________________ ______________________

(Print Name, Title) (Signature)

Date Read:______________________ Result: ________mm induration (Positive / Negative)

Read By: ______________________ ______________________

(Print Name, Title) (Signature)

***Initials:______As a Qualified Health Provider for the above named worker I attest that worker has documented history of: Positive TB Screen, Positive IGRA or Prior TB/Latent TB Infection Treatment.**
Date of:______________Positive TB Screen, Positive IGRA or Proof of TB Infection Treatment

- Worker verbal history only is not acceptable proof. Worker must provide documented proof of positive TB results if available. Worker will be required to fill out *Level One Personnel TB Screen Questionnaire* annually and submit copy of most recent Chest X-ray report indicating no evidence of active TB. Repeat Chest X-ray not required unless new symptoms.

A 2-Step TB Screen MAY be Required – Worker Should Check With Their LOP Representative

The 2nd step must be placed AT LEAST 7 days and NO MORE than 21 days after the **READ** date of the 1st step.
Any PPDs placed outside of this 7-21 day window are considered non-compliant (PA and NJ clinicians – 2-step PPD required).

Physician/Qualified Health Provider Statement
(To Be Completed By MD, DO, DC, PA or NP)

☐ I have examined the individual named above, and to the best of my knowledge, he/she is in good health and is able to work without restrictions. (Physical Demands: stooping, turning, bending, squatting, kneeling and the ability to lift up to 50 pounds; constant/repetitive standing; requires normal, correctable vision and hearing, and the ability to accurately discern color as necessary to perform job functions).

☐ I have examined the individual named above, and to the best of my knowledge, he/she is in good health and is able to work with the following restrictions/limitations:___________________________________

Printed Name	Title	Name and Address Please use Stamp
Physician/QHP Printed Name and Title (Please Print)		
X Signature		
Physician/QHP Signature (Please Sign)		**Physician/QHP Name and Address - Please Use Stamp** (if no stamp available please print – LOP will call clinic/office to verify):
Date:	**Phone:**	
Date of Exam (if differs from signature date):		

Level One Personnel Verification Use Only - Print Clarifying Information Above As Needed		
☐ Date Examined:________	☐ Provider Name:______________________	☐ Provider Title:__________
☐ Date Signed:________	☐ Facility Contact/Location Information______________________	
Verified by: ☐ Phone ☐ Fax ☐ Email	Verified with (Name & Title):______________________	
Level One Personnel Representative Signature	Title	Date / Time

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