MILLENNIUM MEDICAL STAFFING INC.

P: (718) 364-7250 F: (718) 364-7355

AGENCY PRE-EMPLOYMENT HEALTH EXAMINATION
BY PRIVATE PHYSICIAN

Name ____ Title____________ Department____________________
Last First

Date of Birth: _________________________ Social Security # _________________________

1. **TO PHYSICIAN:** *A pre-employment health examination is required for the above-named health care worker. Please enter details of all requested information. All fields are required. Thank you.*

2. **MEDICAL HISTORY:**
   - Any major illness or health impairment____
   - Hospitalization____
   - Serious injury____
   - Allergy____
   - Medication currently being taken:____

3. **PHYSICAL EXAMINATION:**

   T_______________ P______________ R________________ BP_______________ Hght_______________
   Wght_______________
   Gen_________________ HEENT____________________ Neck______________________
   Lungs_______________ Heart_______________ Abd_______________ Ext_______________
   Musculoskeletal_________________________ Neuro________________________________

4. **TWO (2) PPD TESTS (Mantoux) are required:**
   - **PPD TEST 1** Date: __________________ (within last 12 months) Result: ___________ (mm)
     (mm/dd/yy)
   - **PPD TEST 2** Date: __________________ (within past 3 months) Result: ___________ (mm)
     (mm/dd/yy)

5. **CHEST X-RAY** (for positive PPD) Date**:** ________________ Result**:** ______________________
   (mm/dd/yy)

6. **RUBELLA** antibody titer: ________________ date: ___________________ OR vaccine date: __________________
   (mm/dd/yy) (mm/dd/yy)

7. **RUBEOLA**
   - *REQUIREMENTS FOR ALL MILLENNIUM EMPLOYEES*

born before January 1, 1957: antibody titer: ________________________ date: ______________________________
(mm/dd/yy)

OR

2 doses of Live vaccine dates: (1) _____________________ *(2)* _______________________
(mm/dd/yy) (mm/dd/yy)

born Jan 1, 1957 – Dec 31, 1966:
if antibody positive, one dose live vaccine required; if antibody negative, 2 doses live vaccine required;
if no antibody test, 2 doses live vaccine required.

antibody test result: ________________________ antibody test date: ____________________________
(mm/dd/yy)

Live rubeola vaccine dates: (1) ________________________ (2) ______________________________
(mm/dd/yy) (mm/dd/yy)

born on or after January 1, 1967: antibody titer: __________________ date: ___________________________
(mm/dd/yy)

OR

2 doses of live vaccine dates: (1) ________________________ (2) _______________________
(mm/dd/yy) (mm/dd/yy)

8. VARICELLA antibody titer: __________________ date: ___________________________
(mm/dd/yy)

9. HEPATITIS B surface antibody titer: _____________________ date: ___________________________
(mm/dd/yy)

vaccine dates: (1) __________________ (2) _________________ (3) _________________
(mm/dd/yy) (mm/dd/yy) (mm/dd/yy)

OR

- HEPATITIS B DECLINATION FORM

10. MUMPS antibody titer: ________________ date: _________________
(mm/dd/yy)

OR

vaccine dates: (1) ________________ (2) _________________
(mm/dd/yy) (mm/dd/yy)

11. ADULT TETANUS / DIPTHERIA VACCINE (within 10 years) date: _________________________
(mm/dd/yy)

12. INFLUENZA VACCINE date: _______________________
(mm/dd/yy)

13. OTHER REQUIREMENTS:

- 10-PANEL DRUG SCREENING (TOXICOLOGY)
- RESPIRATORY FIT-TEST (N-95)

Physician Name printed or stamp: ____

License number: __________________________ State: ___________________________

Address: ____

____

____

Telephone: __________________________________

____ ______________________________
Physician Signature Date