Holsman Healthcare, LLC
Healthcare Staffing and Consulting Services
Tel: 973-393-5545 / 973-759-1494 / 877-268-9100 Fax: 973-759-0557

Physician's Statement

Name:

The patient named above has been examined by me and considered to be in good physical and mental health, as well as free from communicable diseases. He/she is able to perform all the job duties of the travel nurse profession, to full capacity and without any limitations.

Physicians Name & Phone Number	X Physician's Signature Date
Address of Physician's Office	License Number

Tuberculosis Screening

1. Have you ever had a **POSITIVE** TB skin test? ☐ Yes ☐ No
2. Have you ever received BCG vaccine? ☐ Yes ☐ No
3. Do you have a history of tuberculosis? ☐ Yes ☐ No

☐ **PPD Skin Test** Dose: Lot #: Expiration:

Date Administered: _____ Placed By:_____

Date Read:_____ Read By:_____

Results: ☐ Negative ☐ Positive Size of Induration: mm

☐ **CXR (attach positive PPD)** Date of CXR: _____

(Include copies of all documentation for lab results/readings)

Please indicate if you have had any of the following symptoms for three to four weeks or longer since your last chest x-ray:

- chronic cough ☐ Yes ☐ No
- unexplained productive cough ☐ Yes ☐ No
- production of sputum ☐ Yes ☐ No
- blood-streaked sputum ☐ Yes ☐ No
- unexplained appetite loss ☐ Yes ☐ No
- increased fatigue/tiredness ☐ Yes ☐ No
- unexplained fever ☐ Yes ☐ No
- unexplained weight loss ☐ Yes ☐ No
- chest pains ☐ Yes ☐ No
- persistent night sweats ☐ Yes ☐ No
- shortness of breath ☐ Yes ☐ No

The above health statement is true and accurate to the best of my knowledge and there is no evidence of pulmonary tuberculosis or contagion. I will visit my physician or a local health department if my health status should change.

Signature Date

710 Mill St. Unit H3 Belleville, NJ 07109
877-268-9100 (Phone) 973-759-0557 (Fax)