HEALTH/FREEDOM FROM COMMUNICABLE DISEASE STATEMENT

EMPLOYEE NAME: _____ DATE: _____

I, _____, hereby attest that the state of my health is such that it will enable me to perform the duties of a health care professional. I further specifically attest that I am free of any and all potentially contagious diseases including, but not limited to those listed below:

Anthrax	Chickenpox	Cholera	Diphtheria
Encephalitis	Poliomyelitis	Influenza	Rabies
Leptospirosis	Malaria	Measles (Rubeola	Meningitis
Mononucleosis	Mumps	Whooping Cough	Plague
Hepatitis, types A, B, C	Psittacosis (Ornithosis	Leprosy (Hansen's Disease)	Rocky Mountain Spotted Fever
Rubella (German Measles	Shigeliosis	Shingles	Smallpox
Tularemia	Tuberculosis/TB	Typhoid Fever	Other:

Do you have any of the above or other contagious or communicable disease? ❑ Yes ❑ No

If yes, please list disease(s): _____

❑ I attest that I have read the above listing of contagious/communicable diseases and have reported by listing above. I have also provided any requested documentation from my physicians regarding my ability to work. This information is subject to review of the Hospice Medical Director for employment clearance.

❑ I attest that I have read the above listing of contagious/communicable diseases and am free of any listed or other communicable disease.

Please indicate if you have experienced any of the listed symptoms by checking the Yes or No box.

SYMPTOM	YES	NO
Recent Fever	❑	❑
Fever lasting several weeks	❑	❑
Consistent cough in absence of cold or flu	❑	❑
Coughing blood streaked sputum	❑	❑
Pain in chest when taking a breath	❑	❑
Painful joints	❑	❑
Swollen glands	❑	❑
Unusual tiredness or weakness lasting weeks	❑	❑
Vomiting	❑	❑
Diarrhea	❑	❑
Skin rash	❑	❑
Unplanned weight loss greater than 10%	❑	❑
Night sweats	❑	❑
Recent diagnosis of diabetes, silicosis, HIV disease, renal disease, or liver disease	❑	❑
Recent exposure to someone with active TB	❑	❑

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Are you being treated by a physician? ❑ Yes ❑ No

By signing below, I attest that to the best of my ability, I do not have any of the above symptoms that might indicate that I have a communicable disease at this time

If you answered YES to any of the above symptoms or question, please describe below:

As long as all the above questions are answered “NO”, or “Yes” and are related to another chronic illness the review is complete.

If any questions were answered yes and are not related to another chronic illness, or If you develop any of the symptoms listed above, notify your manager immediately for medical follow-up.

_____
Printed Name

_____ _____
Signature Date

For Company Use Only
Check One:

❑ Employee shows no signs of communicable disease

❑ Employee has identified symptoms and sent for medical follow-up

Summary of Findings
Check One:

❑ Employee has provided documentation from Licensed Independent Practitioner that she/he is free of a communicable disease.

❑ Employee has provided no evidence that she/he is free of a communicable disease such as a LIP note permitting return to work.

_____ _____
Signature of Hiring Manager Completing Review Date