BROOKS ALTERNATIVE AGENCY INC.

Brooks Alternative Agency Inc.

EMPLOYEE MEDICAL INFORMATION CONFIDENTIAL

Name:_____**Social Security #:** _____ **DOB:** _____

Address: _____

_____

I hereby authorize the requested information below to be released to Brooks Alternative Agency Inc..

_____ _____

(Signature) (Print Name)

DATE OF EXAM: _____ **Height** _____ **Weight** _____ **Blood Pressure** _____ **Pulse** ____

TST Test First Test/Date:_____ **Read:**_____ **Reading:**_____ **mm**

TST Test Second Test/Date:_____ **Read:**_____ **Reading:**_____ **mm**

If TST positive, date of chest x-ray: _____ **Results:** _____

Covid Vaccination: First Date:_____ **2nd Date:**_____**Booster Date:**_____

Based on health history, physical examination, assessment, and on laboratory tests performed, this person is free from any health impairment that s a potential risk to the patient, or may Interfere with the performance of his/her duties including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substance which may after the Individuals behaviour.

I have examined the above named Individual and determined that he/she Is health to be adequate for work In the healthcare field.

Physician/Nurse Signature: _____ **Date:** _____

Physician Name: _____

(Print Name)

Address: _____

City/State/ZIP: _____