



Employee/Contractor Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_ Hire Date: \_\_\_\_\_

**Tuberculosis Screening:**

Last screening date: \_\_\_\_\_ New hire: yes      no

Do you have any of the following symptoms?

Cough lasting more than 3 weeks	yes	no
Unintended weight loss	yes	no
Fatigue	yes	no
Low grade fever	yes	no
Night sweats	yes	no
Chills	yes	no
Loss of appetite	yes	no
Pain with breathing	yes	no
Blood in sputum	yes	no

NURSE COMMENTS:

**I understand that if I exhibit any of the above symptoms or am exposed to Tuberculosis at any time during my employment at Trusted Hands Senior Care I must report these symptoms to my employer immediately. I may call the agency at any time to arrange to speak to a nurse to answer questions regarding symptoms or exposure.**

**Hepatitis Exposure:**

**I understand that if I am exposed to any type of hepatitis during my employment at Trusted Hands Senior Care, I must report this exposure to my employer immediately. I may call the agency at any time to arrange to speak to a nurse regarding symptoms or exposure.**

Contractor/Employee Signature \_\_\_\_\_

LPN Signature \_\_\_\_\_ RN Signature(if applicable) \_\_\_\_\_

Agency Representative Signature \_\_\_\_\_

