Alliance
Health Services LLC

EMPLOYMENT RNA/LPN/CMT/GNA/ & CNA REQUIREMENTS

Name of Applicant: _____

You will need the following documentation:

_____ **Unexpired – ID/Driver's License, US Passport, Permanent Resident Card and Work Authorization Card**

_____ **Social Security Card (Original Only)**

_____ **Licenses**

_____ **2 References**

_____ **Pre-employment Physical (No later than 1 year of Application)**

_____ **Annual PPD Result (if positive, you must have Chest X-Ray Report)**

_____ **Void Check for Direct Deposit (MANDATORY)**

REPORT OF TUBERCULOSIS SCREENING

DATE _____

Name _____ Date of Birth _____

TO WHOM IT MAY CONCERN:

The above-named individual has been screened by _____.
(Name of health dept/facility)

_____ A tuberculin skin test (PPD) is not shown at this moment due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

_____ The person has a history of a positive tuberculin skin test (latent TB infection). A follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

_____ The person either is currently receiving or has completed sufficient medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

_____ The individual had a chest x-ray that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

Based on the given information, the individual can be considered free of tuberculosis in a communicable form.

Signature _____ Date _____
(MD or Health Department Official)

Address _____ Phone _____

_____

_____

REPORT OF TUBERCULOSIS SCREENING

DATE _____

Name _____ **Date of Birth** _____

TO WHOM IT MAY CONCERN:

The above named individual has been evaluated by _____.
(Name of health dept/facility)

Tuberculin Skin Test (PPD)

Date given _____ Date read _____

Results : _____ mm _____ Negative _____ Positive

Chest X-ray Report – No active disease

Date of Chest x-ray _____

_____ No evidence of active tuberculosis

The individual listed above has no symptoms or radiographic findings compatible with active tuberculosis. The individual is free of tuberculosis in a communicable form.

Signature _____ Date _____
(MD or Health Department Official)

Address _____ Phone _____

Chest X-ray Report – Abnormal Report

Date of Chest x-ray _____

_____ Chest x-ray abnormal, active tuberculosis to be ruled out

Active tuberculosis cannot be ruled out in the individual listed above. The individual should be referred to a physician or health department for further evaluation.

Signature _____ Date _____
(MD or Health Department Official)

Address _____ Phone _____

HBV VACCINE / WAIVER FORM

Employee Name: _____ Date of Hire:_____
Print Name

Social Security Number: _____

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of getting Hepatitis B Virus (HBV) Infection. **I have been allowed to be vaccinated with Hepatitis B Vaccine, at no charge to myself.** I understand that by refusing this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B Vaccine, I can receive the vaccination series at no charge to me.

I have been informed of my rights to accept or decline the HBV Vaccine. HBV (Hepatitis B Virus) has been fully explained to me.

_____ I choose to waive my rights to receive the HBV Vaccine

_____ I choose to receive the HBV Vaccine and I understand that the vaccine is given in a 3-part series.

Series # 1 Date	Series # 2 Date	Series # 3 Date

_____ _____
Employee Signature *Date*

_____ _____
Agency Rep. Signature *Date*

Alliance
Health Services LLC

Physical Examination Form

To be filled by the Physician

Employee information:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Weight: _____ Height: _____ Allergies: _____

Medical Information:

I have examined the above person; he/she is in sound health to perform the duty of patient care provider.

- □ Does not have signed and symptoms of communicable disease such as tuberculosis.
- □ Does not have physical disability or any form of handicap, that could impact his/her ability to perform patient care services
- □ Does not have any chronic conditions that will affect his / her ability to work as patient care provider.

Recommendations: _____

_____

_____

Physician Signature: _____

Physician Name: _____

Office Address: _____

_____

Telephone Number: _____