



MEDICAL RELEASE AUTHORIZATION
(Please print clearly)

I, _____, do hereby authorize _____, to
Printed Name of Applicant Printed Name of Physician
release to Richards Healthcare Inc and any of its client hospitals or institutions any information acquired in my
recent medical examination which is relevant to my employment as a health care professional.

Signature of Applicant Date

PHYSICIAN'S STATEMENT

I have examined the individual named above, and to the best of my knowledge, he/she is in good physical and
mental health, free of any communicable diseases, and is able to function in his/her profession at full capacity.

Signature of Physician Date

Printed Name of Physician Date of Physical

PHYSICIAN TO COMPLETE THIS SECTION:

Note: History of disease is not current proof of immunity.

TB SKIN TEST Date _____ Results _____

CHEST X-RAY* Date _____ Results _____

*(If TB skin test positive)

RUBELLA TITER Date _____ Results ___ Immunity Present ___ Immunity not present

RUBEOLA TITER Date _____ Results ___ Immunity Present ___ Immunity not present

MMR Immunization Date _____

VARICELLA TITER Date _____ Results ___ Immunity Present ___ Immunity not present

Immunization Date _____

RICHARDS HEALTHCARE EMPLOYEE TO COMPLETE THE FOLLOWING:

I understand the OSHA guidelines for Hepatitis B and need # _____ in the series of three, or booster, in the
series. If a series or booster is required while in the employment of Richards Healthcare please let us know.

I have completed the Hepatitis B series and booster.

Date _____ Signature _____

I understand the OSHA guidelines and **DECLINE** the Hepatitis B vaccination.

Date _____ Signature _____

It is mandatory to fill out this form completely.