|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| **Instructions to Health Provider:**  |  |  |  |  |  |  |  |  |  |  |  |  |
| The Student named below has applied to the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ program with OMCC and needs to submit documentationof fitness for duty and a statement indicating he/she is free from potentially communicable disease(s). |
|
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |   |   |   |   |  |  |  |  |  |  |  |
| Student Name |   |  |  |  | Sex | Date of Birth |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **PHYSICAL/VITAL SIGNS** |  I have examined and certify that he/she is medically capable of performing  |  |  |  |  |  |  |  |
|  |  his/her presented duties. |  |  |  |  |  |  |  |  |  |  |
| Temperature |   |  |  |  |  |  |  |  |  |  |  |  |  |
| Pulse |   |  |   |   |   |   |  |  |  |  |  |  |  |
| Respiratory Rate |   |  | Physician/Clinic Signature |   | Date |  |  |  |  |  |  |  |
| Blood Pressure |   |  |  |  |  |  |  |  |  |  |  |
|   |   |   |   |   |   |   |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | **TUBERCULOSIS (TB) PPD TESTING** |  |  |  |  |  |  |
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| --- |
| ***\* Note: Chest X-Ray*** A positive TB result with the two-step Mantoux test necessitates a Chest X-Ray   Chest X-Ray: (Attach a copy of report) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

 | **1st Step ↓** | Good for 1 Year |  **2nd Step ↓** |  |  |  |  |  |  |
|  | *Read in 48 - 72 Hours* |   | *Applied 7 - 21 days after 1st Step* |  |  |  |  |  |  |
|  |   |   | Date Applied |   |  |  |  |  |  |  |  |
|  |   | Site |   |  |  |  |  |  |  |
|  |   | Signature |   |  |  |  |  |  |  |
|  |  |   | Lot # |   |  |  |  |  |  |  |  |
|  |  |   | Date Read |   |  |  |  |  |  |  |  |
|  |  |   | Signature |   |  |  |  |  |  |  |  |
|  |  |   | Results (mm) |   |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **IF SIGNIFICANT REACTION WAS REPORTED, THE PHYSICIAN REPORT MUST STATE THAT THE STUDENT IS FREE FROM ACTIVE TUBERCULOSIS DISEASE** |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |   |   |   |   |   |   |  |  |  |  |  |  |  |
| **PRE-CLASS HEALTH STATEMENT** |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| I certify that I am free of any lower back ailments, communicable disease, pregnancy limitations, or any other ailments that could prevent me from performing my duties in a satisfactory manner. |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|   |   |   |   |   |  |  |  |  |  |  |  |
| **Student Signature** |  |  |  |  | **Date** |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |