



### HEALTH PROFILE

(To be Completed by Physician or Other Authorized Health Care Provider)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Latex Allergy:  Yes  No

MMR (Measles, Mumps, Rubella) Vaccine Date: \_\_\_\_\_

Mumps: _____	<input type="checkbox"/> Proof of history	<input type="checkbox"/> Vaccine Date _____	Titer _____	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg
Rubella: _____	<input type="checkbox"/> Proof of history	<input type="checkbox"/> Vaccine Date _____	Titer _____	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg
Rubeola: _____	<input type="checkbox"/> Proof of history	<input type="checkbox"/> Vaccine Date _____	Titer _____	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg
Varicella: _____	<input type="checkbox"/> Proof of history	<input type="checkbox"/> Vaccine Date _____	Titer _____	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg

Hepatitis B Series \_\_\_\_\_ Dates: \_\_\_\_\_; \_\_\_\_\_; \_\_\_\_\_ Titer \_\_\_\_\_  Pos  Neg

Hepatitis B Declination: \_\_\_\_\_

PPD/Mantoux Screen: \_\_\_\_\_ Date: \_\_\_\_\_  Satisfactory

TB Questionnaire (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

Chest X-Ray: \_\_\_\_\_ Date: \_\_\_\_\_

General Comments:

\_\_\_\_\_  
\_\_\_\_\_

**I certify that the above person is free from symptoms indicating the presence of an infectious disease and does not have any restrictions which would interfere with the performance of his/her duties performed in the capacity of a \_\_\_\_\_.**  
Position

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Authorized Health Care Provider's Signature

\_\_\_\_\_  
Date

**RELEASE:** I authorize the release of the information contained on the front of this form to be provided to SYNERGY Medical Staffing only. I understand that this health profile is required in order that I may be considered for assignment with SYNERGY Medical Staffing.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date