



HEALTH HYBRID INC.
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Matteson, IL 60443
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Comprehensive Health Statement

Name: _____

Address: _____

Physical Exam:

The above individual has been examined and found to be in good health without evidence of communicable disease and free from health conditions which would be of potential risk to the patient or which might interfere with the performance of the person's duties as a health care worker.

Physician or Nurse Practitioner:

Name: _____ Phone Number: _____

Address: _____

Signature: : _____ Date: _____

PPD Skin Test: Step 1

TB (Mantoux) Test: Date Given: Lot#:	Date Read: : _____ Reading: : _____ <u>mm</u>
Circle: Right Forearm or Left Forearm	Circle: Negative or Positive
Given By (signature): : _____	Read By (signature): : _____
PPD Skin Test: Step 2 (between 1 week and 3 months after step 1, placed in opposite arm)	Note: recent(within 5 years) Chest X-ray and annual TB checks are required if PPD skin test is positive
Date Given: _____ Lot #: _____	Date Read: : _____ Reading: : _____ <u>mm</u>
Circle: Right Forearm or Left Forearm	Circle: Negative or Positive
Given By (signature): : _____	Read By (signature): : _____

If unable to undergo a TB Test due to a past positive TB Test, a Chest X-Ray is acceptable. Please complete Annual TB Questionnaire form and submit to our office.

Date: _____ Chest X-Ray Results: _____
 Please attach radiological report.