Premier Choice Health Services
State Tested Nurse Aide Training
Health Certificate

_____
Last Name First Name Middle

_____
Address City State Zip Code

_____
Employer Employer's Phone Number

Is this person free of communicable disease? _____

Have you noted any emotional or physical condition(s) which might prevent this person from fulfilling his/her duties as a Nurse Aide? _____

If so, please describe:

_____

_____

_____

Essentials of Physical Exam		
Temperature	**Respiration**	**Pulse**
Blood Pressure	**Weight**	**Height**
Any pertinent findings: **Date of Physical Exam:**		

PPD

Date of 1st Step: _____ Date 1st Step Read: _____ Results: _____

Date of last PPD screening: _____ if positive, Chest X-ray Results: _____

After the TB test is given, you will return in 2 days and have it read. The test must be signed and dated. Any unsigned results will not be accepted.

Signature of Physician: _____ Date _____
Name of Physician: _____
Address: _____