Silver Touch
Home Healthcare

PO Box 122
Merrimack, NH 03054

Phone: 603-424-9479
1-800-642-3686
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Employee Health Record

A certificate of health, signed by a physician is required for all employees of Silver Touch Home Health Care. prior to hire and must be repeated at a minimum of every five years. The employee completes and signs, Sections I, II and III and submits the document to a physician, nurse practitioner or Physician Assistant for completion and signature, in Section IV.

I. The employee must complete Sections I, II, and III.

Name: _____ Title: _____ SS# _____

Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

II. Please indicate with a check (□) if you have or have had, any of the following:

Allergies to cats	□	Back Problems	□	Heart Problems	□
Allergies to dogs	□	Chronic medical condition	□	Skin Allergies	□
Allergies to Latex	□	Hearing Impairment	□	Speech Impairment	□
Allergies to other pets	□	Neck/shoulder Problems	□	TB or exposure to TB	□
Allergies to smoke		Other Communicable Diseases	□	Other	□

III. **Medical History**. Information is used to assure appropriate placement in client's homes and for Emergency purposes only. The information contained herein will remain confidential.

A. Do you currently have any illnesses or medical conditions that may interfere with your ability to perform your job duties? { Yes { No

If "yes", please describe. _____

B. In the past 12 months, have you had any illnesses or injuries that may interfere with your ability to perform your job duties? { Yes { No If "yes", please describe. _____

C. If required, would you be willing to have your blood/urine screened for alcohol/drugs, as a condition of employment? { Yes { No

If "no", please explain. _____

D. Have you ever had a positive tuberculosis test? { Yes { No

If 'yes", please explain. _____

Chest x-ray done _____ Results _____

Employee Signature : _____ **Date:** _____

IV. To be completed by a physician, physician's assistant or a nurse practitioner.

Employees of Silver Touch Home Health Care. must be free of any symptoms of communicable disease and able to perform a variety of job duties that include but are not limited to, the ability to sit, stand or kneel for unpredictable periods of time. They must be able to safely drive a vehicle, assist with patient transfers, and **routinely lift up to 50 pounds**.

I have examined the above individual. I certify that he/she is free of any communicable disease and unless indicated below, does not have any condition that would interfere with the performance of his/her job duties.

Limitations: _____

_____

_____

_____

_____

Practitioner's Signature **Date** **Phone Number**