Where better days blossom.

BON HOMIE LTD.
ADULT DAILY LIVING CENTER

Staff Medical Evaluation Form

- This evaluation is to be completed prior to employment and every other year there after.

Name: _____ **Date:**_____

Address:_____

Age: _____ **DOB:**_____ **Sex: Male / Female**

I have examined the aforementioned , who is employed by or/applying for employment with Bon Homie, Ltd.:

_____I find this individual **to be free of** physical limitations, conditions, or communicable diseases that would affect their performance or the health of other individuals at the center.

_____ I find this individual **to have** physical limitations, conditions, or communicable diseases that would affect their performance or the health of other individuals at the center.

Please list physical limitations, conditions, or communicable disease (to the extent that confidentiality laws permits) and any precautions that could be taken to allow this indidual to safely work in the center without affecting the health or safety of the clients and staff: _____

_____

_____

Tuberculin Test Date Applied	Arm Used For Testing	Manufacturer / Expiration	Signature/Credentials
Date Read	**Induration (+/-)**	**Results (mm)**	**Signature/Credentials**
Note: ONLY a MD/DO, NP, PA, RN, or LPN is permitted to READ the TB Test			

Follow-up of Significant testing:_____

_____

Physician's Signature:_____

Address: _____

_____

Phone Number: _____