FOMEN NURSING ASSISTANT TRAINING ACADEMY
CERTIFIED/GERIATRIC NURSING ASSISTANT TRAINING PROGRAM
HEALTH CLEARANCE FORM

www.Fomennursingassistant.com E-mail: info@fomennursingassistant.com

NAME: ____ DATE OF BIRTH______________ AGE__________

TUBERCULIN SKIN TEST

Prior History: Positive_____ Negative_______ Date:_________

Applicants with history of negative skin test 12 months or longer require a new skin test	Applicants with history of positive skin test:
Date administered: _______________	Date of chest x-ray:__________
Date read: ____________	Tuberculosis cleared yes____ no ___
Positive___ Negative____ size:____ mm	Symptom screen (To be completed by applicant):
	1. Productive cough of more than 2weeks duration yes no
	2. Brings up sputum everyday for 1week or more yes no
	3. Blood present in sputum yes no
	4. Chronic feeling of fatigue of more than 2week Duration yes no
	5. Low grade fever for more than 1 week duration yes no
	6. Night sweats yes no
	7. Unexplained weight loss of 8 pound or more yes no
	8. Loss of appetite yes no

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TETANUS

Previous Tetanus immunization within 10 years: yes___ no____

If no, immunization indicated: Accepted _____ Declined____ Other_______

MMR

Previous MMR immunization: yes___ no____

If no, immunization indicated: Accepted _____ Declined____Other_______

VARICELLA

Previous history of Varicella: yes___ no___

Previous varicella immunization: yes___ no____

If no, immunization indicated: Accepted _____ Declined_____Other_______

HEPATITIS B VACCINATION

Previous Hepatitis B Vaccination yes___ No____

HBV: 1ST dose date_________ 2nd dose: ________ 3rd Dose date______ declined : _____

Applicant is fit to train/work as a certified nursing assistant: yes ____ no _____ other_______

____________________________ ___________________________________

MD, PA, NP, RN name /title MD, PA, NP, RN signature/date