



**HEALTH PROFILE**  
(To be Completed by Primary Care Provider)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Vital Signs: P \_\_\_\_\_ R \_\_\_\_\_ BP \_\_\_\_\_ Latex Allergy:  Yes  No

Blood: CBC: \_\_\_\_\_

Varicella:  Proof of history  Titer \_\_\_\_\_

MMR (Measles, Mumps, Rubella) Vaccine Date: \_\_\_\_\_

Mumps: \_\_\_\_\_  Proof of history  Vaccine Date \_\_\_\_\_  Titer \_\_\_\_\_

Rubella: \_\_\_\_\_  Proof of history  Vaccine Date \_\_\_\_\_  Titer \_\_\_\_\_

Rubeola: \_\_\_\_\_  Proof of history  Vaccine Date \_\_\_\_\_  Titer \_\_\_\_\_

PPD/Mantoux Screen: \_\_\_\_\_ Date: \_\_\_\_\_  Positive  Negative

Chest X-Ray: \_\_\_\_\_ Date: \_\_\_\_\_  
(if positive TB Screen)

General Comments:  
\_\_\_\_\_  
\_\_\_\_\_

**I certify that the above person is free from symptoms indicating the presence of an infectious disease and does not have any restrictions which would interfere with the performance of his/her duties performed in the capacity of a \_\_\_\_\_.**  
Position

\_\_\_\_\_  
Print Primary Care Provider's Name Primary Care Provider's Signature Date

**RELEASE:** I authorize the release of the information contained on the front of this form to be provided to ATC Healthcare Services, Inc. only. I understand that this health profile is required in order that I may be considered for assignment with ATC Healthcare Services.

\_\_\_\_\_  
Signature Date