Medical Staffing Partners

Health Screening Form

Name of Healthcare Worker: _____
Date of Birth: _____
Date form Completed: _____

Please answer the following questions:

1. Foreign-born, lived in or traveled to areas that have a high Tuberculosis prevalence? (Areas of high Tuberculosis prevalence are Africa, Asia and Latin America.) Yes ☐ No ☐
2. Employee or resident of facilities for long-term care (correctional institutions, nursing homes, mental institutions)? Yes ☐ No ☐
3. Healthcare worker? List # of years _____ Yes ☐ No ☐
4. Intravenous drug use? Yes ☐ No ☐
5. Compromised immune system (HIV, steroid drugs for 2 weeks or longer, cancer, radiation, or chemotherapy)? Yes ☐ No ☐
   If you answer yes to this question, please explain:
   _____
6. Have you ever been diagnosed with Tuberculosis? Yes ☐ No ☐
7. Were you treated? Yes ☐ No ☐
8. Contact with a person known to have Tuberculosis? Yes ☐ No ☐
   If you have been a Healthcare worker, please list the States and countries you have worked in._____
9. Have you had a previous BCG vaccination? Yes ☐ No ☐
   (BCG is given in some foreign countries to prevent tuberculosis)

Do you have any of the symptoms listed below?

1. A bad cough lasting 3 weeks or longer? Yes ☐ No ☐
2. Coughing up blood or sputum (phlegm from deep inside the lungs)? Yes ☐ No ☐
3. Weakness or fatigue? Yes ☐ No ☐
4. Unexplained weight loss? Yes ☐ No ☐
5. No appetite? Yes ☐ No ☐
6. Fever or chills that are prolonged or unexplained? Yes ☐ No ☐
7. Sweating at night (soaking the sheets)? Yes ☐ No ☐

_____ Date: _____
Employee's Signature

_____ Date: _____
Medical Staffing Partners, Inc. Signature