Liken Home Care

Please place physician office stamp here or fill in office address and phone number.
Forms without a physician office stamp or office address & phone number, will not be accepted.

Place Office Stamp Here

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☐ **EMPLOYEE PHYSICAL** _____
(Physician Signature)

I certify that _____ has been examined by me on _____
(Employee Name) (Date)
and found to be free of communicable disease and is able to work without any restrictions.

☐ **TUBERCULOSIS TESTING** _____
(Physician Signature)

Liken Home Care requires the 2-step Tuberculosis (Mantoux) skin test be implemented for all employees upon hire. If a TB skin test is given with negative results, a second test must be repeated within 1-3 weeks after initial skin test. Negative test results must be made available prior to assumption of job responsibilities and a One-Step completed annually thereafter.

TB One-Step Method

_____ _____ _____
Date Given Right Arm Left Arm

Lot# _____ Given by:_____

Expiration Date _____ _____ _____ _____
Date Read Positive / Negative Results in mm

Read by: _____

TB Two--Step Method

_____ _____ _____
Date Given Right Arm Left Arm

Lot# _____ Given by: _____

Expiration Date _____ _____ _____ _____
Date Read Positive / Negative Results in mm

Read by: _____

For any person who has had a positive skin test, a chest x-ray is required. The results and a statement from a physician indicating the employee is free from infection and not infectious at this time must be submitted. A person with a positive skin test should never have another; however, as part of your annual physical, you must be evaluated for the following symptoms. If no symptoms are present, your physician must indicate that an annual chest x-ray is not necessary.

- **Difficult Breathing**
- **Persistent Cough**
- **Blood in Sputum**
- **Night Sweats**
- **Loss of Appetite**
- **Weight Loss**
- **Chills**
- **Fever**
- **Fatigue**
- **Chest Pain**
- **Exposure to TB**
- **Positive Skin Test**

☐ **Initial Chest X-Ray (if test positive):** _____ _____
Statement of Results Attached Date (Physician Signature)

Annual Chest X-Ray (if indicated): ☐ ☐ _____ _____
Statement of Results Attached **NO** **YES** Date (Physician Signature)