Health Examination Form
Messiah University
Nurse Aide Training and Competency Evaluation Program

**Must be completed within 1 year of the course start date.*

To be completed by applicant:

Name:_____

Address:_____

_____

Phone:_____

Date of Birth: _____

To be completed by health care provider (choose one):

Two-step Tuberculin Test (PPD)	**or**	**QuantiFERON TB Gold Test**
First step		Date obtained:
Date administered:		Date of results:
Date read (48-72 hours after placement):		Results*:
Results in mm*:		Negative/Normal
Read by:		Positive/Abnormal
Second Step (7-21 days after first step administered)		Indeterminate
Date administered:		
Date read (48-72 hours after placement):		
Results in mm*:		
Read by:		

*If PPD or QuantiFERON Gold is positive, a chest x-ray must be obtained.

If a chest X-ray was obtained, a copy of the results is attached.

- ☐ Yes
- ☐ Date of Results:_____

Is the applicant able to perform the duties of a nurse aide?

- ☐ Yes
- ☐ No

I certify that this applicant was examined and believe them to be free of communicable disease in a communicable state.

- ☐ Yes
- ☐ No

Is the applicant free from restrictions or limitations? If no, briefly explain the restriction or limitation.

- ☐ Yes
- ☐ No: _____

_____

Provider Name: _____

Provider Signature: _____ **Circle One:** MD, DO, PA, CRNP

Address:_____
Phone:_____ **Date:**_____