DIRECT DEPOSIT VERIFICATION FORM

Employee Name ____ SSN __________________

Job Title ____

Home Phone ___________________________ Cell Phone _____________________________

Bank Name: (example: PNC Bank) ____

Routing Number ________________________ Account Number ________________________

Mailing Address ____

I, ______________________________________ hereby authorize H&C Nursing Care Services to

deposit my wages to this account.

Signature ____ Date ___________________

525 Highland Boulevard Suite 105
Coatesville, PA 19320
Phone: (484) 359 4357
Fax: (484) 359 4372

H&C Nursing Care

525 Highland Boulevard Suite 105 Coatesville, PA 19320
Phone: (484) 359-4357 Fax: (484) 359-4372

PRE-EMPLOYMENT PHYSICAL

Name: ______________________________ Male ☐ Female ☐

Address: ______________________________ Date of Birth: ______________

Telephone#: ______________________ SS# (Last 4 digits): ______________

Medical Practitioner: Please complete the following:

Height: ________ Weight: ________ BP: ________ T.P.R ________

1. Immunizations and Lab Tests:

* PPD # 1(Mantoux) Pos ☐ Neg ☐ Date Implanted: __________
Date Read: __________

* PPD # 2: (Mantoux) Pos ☐ Neg ☐ Date Implanted: __________
Date Read: __________

Chest X-ray: (If PPD is positive) Pos ☐ Neg ☐ Date: __________
(Attach lab report)

* Rubella Pos ☐ Neg ☐ Titer: ______ Date: ______

* Rubeola (if born after 12/31/56) Pos ☐ Neg ☐ Titer: ______ Date: ______

* MMR Vaccine (alternate for Rubella & Rubeola) Date: ______ Date: ______

* Varicella Vaccine Date: __________

* Hepatitis B Vaccine (optional) #1 Date: ______ #2 Date: ______ #3 Date: ______Titer: ______

Medical Exemption from Influenza Vaccine:
Yes ☐ (complete attached exemption form) No ☐ (complete information below)

* Seasonal Influenza Vaccine (for applications from Sept. to Mar.) Date: ____________

Type of vaccine: ____________________ Dose: ______________
Manufacturer & Lot #: ________________ Site of Administration: __________

Person administering the vaccine:
Name: ____
Last Name First Name
Signature: ______________________ Title: ______________________
Reactions (if applicable): ______________________________________

2. Review of Systems:

Cardiovascular __________ Muscular __________
Digestive __________ Nervous __________
Endocrine __________ Reproductive __________
Excretory __________ Respiratory __________
Immune __________ Skeletal __________

Present Medication(s): Yes☐ No ☐ (If yes, attach list of medications, dosages, and purpose)

Name: ____ SS# (Last 4 digits): _______________

2. Past Medical History

	YES	NO
Any serious problems, surgery	☐	☐
Tuberculosis	☐	☐
Diabetes	☐	☐
Mental/Behavioral Disorder	☐	☐
Cardiovascular Disease	☐	☐
Hypertension/Hypotension	☐	☐
Asthma	☐	☐
Epilepsy/Seizure Disorder	☐	☐
Cancer	☐	☐
Kidney Disease	☐	☐
Drug/Alcohol Abuse	☐	☐
Allergies	☐	☐
Other _________________________________		

3. Tuberculosis (TB) Questionnaire/Screening

	YES	NO
Exposure to TB at Work/Home	☐	☐
Positive Chest X-Ray	☐	☐
Unintended Weight Change (+/- 10 lbs)	☐	☐
Persistent Cough	☐	☐
Conversion to Positive PPD	☐	☐
Low Grade Fever	☐	☐
Unexplained fatigue	☐	☐
Blood Streaked Sputum	☐	☐
Active TB	☐	☐
Night Sweats	☐	☐
Loss Appetite	☐	☐
Clear, Yellow or Dark Sputum	☐	☐

I certify that I have examined the above-named individual and found him/her to be free of any addiction/ habituation to depressants, stimulants, narcotics, illegal drugs, or alcoholic substances. Yes ☐ No ☐

I certify that I have examined the above-named individual and found him/her to be:

[ ] Fully Employable – No limitations

[ ] Employable – Suggest Follow Up and/or completion of: ____________________________________

[ ] Not Currently Employable – Recommend Additional Testing /Treatment and/or Follow Up as soon as possible for: ____

Medical Practitioner's Signature ____________________________________ Date: _______________

Address: ____ Phone #: ____________________________

Title: ____ **Office Stamp:**

License #: ____

Please note:

- **Physical is not acceptable without Medical Practitioner's stamp; which includes practitioner's name, address, phone # and license #. Form must be stamped and signed.**
- **If applicable, a copy of Chest X-Ray Report must be attached**
- **Toxicology Screening will be scheduled by H&C Nursing Care & Staffing Agency.**