JACE Home Healthcare Services, LLC
336 Mulberry Street
Darby, Pa 19023
Cell #: (610) 915-0040
Email: inquire@jaceservices.org

Annual Physical Form

JACE Home Healthcare Services LLC requires pre-employment physical and TB screening for consideration for employment or contract services.

Current employees and contractors are required to update their physical and TB screening in compliance with company policy and State/Federal regulations, as indicated for the program in which they work.

PART I: BACKGROUND INFORMATION (to be completed by Applicant/Employee/Contractor) PRINT ONLY

Last Name: _____ First Name: _____Middle Initial: _____

Date: _____ Sex: Male Female Job Title: _____

Address: _____
(Street) (City) (State) (zip)

Primary Cell Number: (_____)_____ Email: _____

Emergency Contact: Name: _____ Relationship: _____

Cell Number: (_____)_____ Email: _____

Please note that a negative answer to any of the following questions will not necessarily disqualify you from employment

Based on the job description, can you perform the job and its responsibilities as listed, with or without reasonable accommodation?

Yes _____ No _____ If No, please explain: _____

_____

Based on the job description, are you physically and psychologically fit to assist an individual with physical and/or developmental disabilities?

Yes _____ No _____ If No, please explain: _____

Reasonable Accommodation Needed: _____

_____

_____ Date: _____
Applicant/Employee/Contractor

PART II: CONSENT FORM (to be completed by Applicant/Employee/Contractor)

I acknowledge that I must undergo an annual medical examination as part of my employment with JACE Home Healthcare Services, LLC, for compliance with State and Federal regulations. This includes consent for a medical exam and possible blood or urine tests to ensure I am free from health impairments that may pose risks to individuals or disrupt operations.

I certify that I do not use illegal drugs or misuse narcotics or controlled substances. I understand that a drug screening may be included, and employment may be denied based on results.

I authorize my physician to share all examination information with JACE Home Healthcare Services, LLC, which will keep the information confidential except as required by law. I acknowledge that providing false information may result in discharge or denial of employment.

_____ _____ _____
Print Name Signature Date

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PART III: MEDICAL EXAMINATION FORM (to be completed by a Physician)

Patient Full Name: _____
Last Name First Name Middle Initial

PHYSICAL EXAM

I certify that this patient has been examined on _____(date) for occupational placement.

Blood Pressure: _____ Height: _____ Weight: _____

I certify that this patient is _____(Fit) _____(Unfit) to assist an individual with physical and or developmental disabilities.

Please write any comments: _____

_____

TUBERCULOSIS (TB) PPD SCREENING 2 STEPS

The patient is required to complete a TB screening for employment/contract. JACE Home Healthcare Services includes a screening record section on this physical form. If a skin test cannot be completed due to past positive PPD Results or BCG vaccination, the patient may provide a negative chest x-ray report with the results interpreted by a physician. (Every two years by the Mantoux method, if an X-ray should be done)

Step I: Date Test Administered: _____ Date Test Result Read: _____
(Results MUST be read within 48-72 hours after initial administration)

Results: **NEGATIVE** _____ **POSITIVE**: _____ (if results are positive, a chest x-ray is needed, along with a radiology report)

Step II: Date Test Administered: _____ Date Test Result Read: _____
(Results MUST be read within 48-72 hours after initial administration)

Results: **NEGATIVE** _____ **POSITIVE**: _____ (if results are positive, a chest x-ray is needed, along with a radiology report)

Chest X-Ray Report (Radiology report must be attached)

Chest X-Ray Completed: _____ X-Ray Results: _____

Blood Exam Method (Lab sheet must be attached)

Date of Blood Exam: _____ Result of Blood Exam: **NEGATIVE** _____ **POSITIVE**: _____

COMMUNICABLE DISEASE STATEMENT

Is this patient free of communicable diseases? _____YES _____NO

FACILITY/MEDICAL CARE PRACTITIONERS INFORMATION

_____ _____
Name of Physician Signature

_____
Address Telephone