HORIZON NURSING SERVICES

4765 S CONGRESS AVE
LAKE WORTH, FL 33461
PHONE: (561) 432-1932
FAX: (561) 432-1492

Physician's Statement

Patient's Name: _____ Date: _____

I have examined _____ and in my opinion she/he is physically and mentally capable of performing the duties of a caregiver and **appears to be free from communicable diseases.**

Mantoux Method TB Skin Test

Test Date: _____ Results: Negative _____ Positive _____

Read Date: _____ Read By: _____

CHEST X-RAY

Test Date: _____ Results: Negative _____ Positive _____

_____ This individual appears to be free from communicable disease.

_____ This individual should be removed from patient contact until further notice.

_____ _____
Physician's Signature **Date**

_____
Physician's Name

_____
Address

_____

_____
Telephone

****This form must be completed by a licensed MD, PA or ARNP****

Revised 04/2016