



DEAR FIVE STAR HOME HEALTH CARE AGENCY EMPLOYEE:

Please, be advised, that you need to **renew the annual medical examination** or you will be **SUSPENDED** from all work assignments (as per NYS Department of Health regulation) as Five Star employee.

Please review the list of documents below you have to submit to Five Star HHCA during **ONE MONTH** since you received this letter.

- ✓ **Physical Exam (Signed by Employee & Physician)**
- ✓ **TB Screen Form**
- ✓ **Drug Screen - only for HHA/PCA (Lab Report required!)**

If you have any questions, please call HR Department at **(718) 676-9977**. Please mail it to us or fax it over to **(718) 676-9960** or send it through email: homecare@fivetsarlhcsa.com

Por favor recuerdese que usted tiene que reaser su fisico antes **si es que usted no lo tiene listo en la fecha endicada usted sera SUSPENDIDO(A) de su caso(s) hasta que recibimos su nuevo fisico**. Por favor, revise la lista de documentos abajo. Usted tiene que someterse a Five Star durante **UN MES** de recibir esta carta. Ademas tambien tiene que llenar completamente los formularios que nosotros mandamos a usted (es) y porfavor tiene que re-enviarlos a nosotros a nuestra oficina, si usted tiene preguntas porfavor llamanos al **(718) 676-9977**.

- ✓ **Examen Físico (Firmado por Empleado y Médico)**
- ✓ **Diagnostico de la TB**
- ✓ **Drug Screen - solo para HHA/PCA (Informe de laboratorio necesario!)**

Пожалуйста обратите внимание что вам требуется пройти **ежегодный медицинский осмотр** у врача и сдать необходимые анализы в течение **ОДНОГО МЕСЯЦА** с даты получения этого уведомления. В ином случае вы будете **ОТСТРАНЕНЫ** от вашей работы как хоматенд в нашем офисе.

Если у вас возникли вопросы, пожалуйста, обратитесь в HR Department по телефону **(718) 676-9977**. Результаты обследования вы можете прислать нам по почте или по факсу **(718) 676-9960** или по электронной почте homecare@fivestarlhcsa.com

Список необходимых документов:

- ✓ **Медицинское обследование**
- ✓ **Анкета на туберкулёз**
- ✓ **Тест на наркотики- только для HHA/PCA (обязательно лабораторная распечатка!)**

请注意，根据公司系统显示，你下列的体检报告已经或即将到期，从收到信开始算必须在一个月内提供新的体检报告给 Five Star。

年度体检表（由员工和医生签名）

皮试

尿毒--亲人计划不需要

根据纽约卫生局规定，所有的家庭护理必须在文件齐全的前提下方可继续工作，告）请尽快与你的家庭医生联系。如有任何问题欢迎致电人事部 **(718) 676-9977**。请邮寄或传真以上文件到 **(718) 676-9960** 或发邮件到, homecare@fivetsarlhcsa.com



3044 Coney Island Ave – 4th Floor, Brooklyn, NY 11235
Phone: 718-676-9977 | Fax: 718-676-9960
Email: homecare@fivestarlhcsa.com

PRE-EMPLOYMENT PHYSICAL EXAMINATION FORM

NAME: _____

DATE OF BIRTH: _____

I. PAST MEDICAL / PSYCHOLOGICAL HISTORY

Tuberculosis: _____ No Yes
Diabetes: _____ No Yes
Heart or Cardiovascular Disease: _____ No Yes
Hypertension: _____ No Yes
Cancer: _____ No Yes
Kidney Disease: _____ No Yes
Allergies (if yes, specify below): _____ No Yes

Epilepsy or seizure disorder: _____ No Yes
Drug alcohol abuse or addiction: _____ No Yes
Psychiatric or Behavioral Disorder: _____ No Yes
Low back pain: _____ No Yes
Other: _____

II. MANDATORY VACCINES/IMMUNIZATION AND LAB TESTS (TO BE COMPLETED BY DOCTOR)

PPD (MANTOUX) or Quantiferon

DATE GIVEN: _____
DATE READ: _____
RESULTS:
NEGATIVE: _____ mm, POSITIVE: _____ mm
Quantiferon - Attach lab work report required!

DRUG SCREEN CHAIN OF CUSTODY

DATE DRAWN: _____
RESULTS:
 NEGATIVE POSITIVE
Attach lab work report required!

AND

! IF POSITIVE, PROVIDE CHEST X-RAY RESULTS: DATE _____ RESULTS _____

RUBELLA: MMR BOOSTER (if needed):

DATE: _____ DATE: _____
TITER: _____ LOT#: _____
RESULTS: EXP. DATE _____
 IMMUNE NOT IMMUNE

RUBEOLA:

DATE: _____
TITER: _____
RESULTS:
 IMMUNE NOT IMMUNE

MMR BOOSTER (if needed):

I MMR DATE: _____
LOT#: _____
EXP. DATE: _____
II MMR DATE: _____
LOT#: _____
EXP. DATE: _____

AND

Attach lab work report required!

III. FLU VACCINE: DATA GIVEN: _____ LOT#: _____ EXP. DATE: _____

IV. REVIEW OF SYSTEMS (TO BE COMPLETED BY DOCTOR)

HEAD/NECK: _____ ABD-GI: _____ ENDOCRINE: _____
EENT: _____ GU: _____ SKIN: _____
RESP: _____ MUSK – SKEL: _____ HEIGHT: _____
CARDIOVASC: _____ NEURO: _____ WEIGHT: _____

V. DOCTOR

I hereby certify that the above named patient does not have any limitations for employment in the health care field, and contact with patients and other staff. There is no health impairment present that is of potential risk to the employee, patient, family, or other employees, or that may interfere with the performance of his or her duties. I have questioned the patient and see nothing to contradict the patient's assertion that he or she is not habituated or addicted to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

PHYSICIAN'S SIGNATURE _____ **EXAM DATE:** _____
DOCTOR'S NAME (PRINT): _____ **PHYSICIAN'S LICENSE#:** _____

**PLEASE USE
PHYSICIAN'S STAMP!**



TB SCREEN FORM

(Please complete this form ONLY if this employee had a Positive PPD)

Tuberculosis Questionnaire

Employee Name: _____ Evaluation Date: _____

Since the employee has a history of a positive Tuberculosis Skin Test, Five Star Home Health Care Agency requires an annual screening questionnaire is be completed by a physician. If the employee has experienced any of the following symptoms, a chest x-ray is indicated.

- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| 1. Chronic Cough | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Fever | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Night Sweat | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Unexplained Weight Loss | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Hemoptysis (coughing up blood) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Hoarseness | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Wheezing | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Shortness of Breath | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. Chest Pains | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

According to the Center for Disease Control & Prevention an initial chest x-ray needs to be completed for any person with a positive PPD-test, and pulmonary symptoms suggestive of TB. Although there are no data to support the use of a routine chest x-ray for persons whom are asymptomatic, more frequent monitoring of TB should be considered for those who are at increased risk for development of active TB.

Five Star Home Health Care Agency requires a chest x-ray be completed and on file within 30 days of any newly reported positive PPD results, and every 10 years thereafter.

Physician/RN Name: _____ Physician/RN Signature: _____

LICENSE #: _____ Date of last Chest X-ray: _____

DOCTOR / RN Stamp below: ↓