Bee Well Home Health Care

Compassionate Care at Your Doorstep!

HEALTH STATEMENT

NAME OF PERSON SCREENED: _____

In my opinion, above individual is in reasonably good health and appears to be free from apparent signs or symptoms of a communicable disease, including tuberculosis and does not constitute a risk to any person/patient.

TB TEST

PPD Given On: _____/_____/_____

PPD Read On: _____/_____/_____ PPD Results: ___ Positive ___ Negative

Date of Chest X-Ray: _____ Results: _____

_____ _____/_____/_____

PRINT NAME (Physician, ARNP, PA) Date

x_____

SIGNATURE

_____

License Number

_____

Phone

_____

Address

RETURN INSTRUCTIONS:

We can also accept this fully completed form by FAX to: **954-919-9669** or by mail to:
Bee Well Home Health Care, 1909 Tyler St., Suite 604, Hollywood, FL 33020