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Health Care Staffing
 Services Certification by
 The Joint Commission

PHYSICIAN'S STATEMENT – ANNUAL RENEWAL

(Please print clearly)

Applicant's Full Name: _____

Note: It is the responsibility of the applicant to have their physician fill out the appropriate section of this form.

Physician to complete the following:

I have examined the individual named above, and to the best of my knowledge, he/she is in good physical and mental health, free of any communicable diseases, and is able to function in his/her profession at full capacity. By signing below I certify that the above information is valid.

Signature _____ *Date* _____

Printed Physician's Name

Applicant to complete the following:

HEPATITIS B VACCINATION (Check and Sign Applicable Statement)

___ I understand the OSHA guidelines and have **COMPLETED** the Hepatitis B Vaccine Series.

Signature _____ *Date* _____

___ I understand the OSHA guidelines and **DECLINE** the Hepatitis B Vaccination.

Signature _____ *Date* _____

___ I understand the OSHA guidelines and need # _____ or booster, in the series. Please arrange for me to receive this dose of the vaccine.

Signature _____ *Date* _____

TETANUS VACCINATION DECLINATION

I, _____, RN, understand that I have been requested to supply proof of Tetanus Vaccination or agree to the vaccination prior to placement with Critical Options. However, I decline the Tetanus Vaccination. Furthermore, I understand that my refusal may limit my placement options in that I understand I cannot be placed at a Company client (hereinafter "Facility") that requires the Tetanus vaccination.

Therefore, in consideration of my employment with Company and placement at a Facility, I agree to hold harmless both Facility and Company, their owners, directors, employees, staff, and agents, from any and all liability arising out of my refusal of the Tetanus Vaccination.

Signature _____ *Date* _____