Community Colleges of Spokane

Reset Form

Spokane Head Start/ECEAP/EHS
PRE-EMPLOYMENT HEALTH EXAMINATION

APPLICANT[1] INFORMATION to be completed by CCS

Date _____

Name _____

Job position _____

Department _____

Supervisor _____ Phone _____

Center _____ MS _____

PROVIDER INFORMATION to be completed by provider

PLEASE PRINT

Clinic name _____ Provider's name _____

Provider's title _____ Phone _____

Mailing address _____ City _____ St _____ ZIP _____

EXAMINATION RESULTS to be completed by provider

Date of examination _____

Visual examination of all skin likely to come into contact with children during routine care is free of signs of communicable disease or infection: ☐ Yes ☐ No

Does applicant report any recent episodes or exposure to communicable diseases? ☐ Yes ☐ No

If yes, describe site and recommended treatment:

_____

Does applicant report any past occurrence of symptoms of communicable disease or infection? ☐ Yes ☐ No

If yes, describe treatment: _____

TB skin test: ☐ Negative ☐ Positive

Comments: _____

Provider signature _____ Date _____

[1] Applicant who has been given a conditional offer of employment.

PATIENT AUTHORIZATION

I give my authorization for these records to be released to the Community Colleges of Spokane Human Resources Office.

Applicant Signature: _____ Date: _____

UPON COMPLETION, MAIL FORM TO:
Community Colleges of Spokane, Human Resources Office,
501 N Riverpoint Blvd, MS 1004, PO Box 6000, Spokane WA 99217 6000
AND FAX TO: 509 434 5055

Form approved by AAG March 2004.