



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

## APPLICANT<sup>1</sup> 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 \_\_\_\_\_

Does visual examination of all skin likely to come into contact with children during routine care exhibit 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:

\_\_\_\_\_

TB skin test:  Negative  Positive

Comments: \_\_\_\_\_

Provider signature \_\_\_\_\_ Date \_\_\_\_\_

<sup>1</sup>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.