



Jazz Home, LLC

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PHYSICIAN'S STATEMENT

Medical Release

Authorization I, _____ do hereby authorize, _____, to release to Jazz Home, LLC, its affiliates, and any of its Client hospitals or institutions any information acquired in my recent medical examination that is relevant to my employment.

Signature _____ **Date** _____ **Social Security Number** _____

Printed Name _____ **Date of Birth** _____

Physician to Complete this Section

TB Skin Test Date: _____ Results: _____

Chest X-ray (if TB test positive) Date: _____ Results: _____

Rubella Titer Date: _____ Results: _____

Rubella Titer Date: _____ Results: _____

(Exempt if born before 1957)

Mumps Titer Date: _____ Results: _____

MMR Dates: 1. _____ 2. _____

Varicella Titer Date: _____ Results: _____

(History of Chicken Pox)

History Date: _____

Vaccine Date: _____

Hepatitis B Titer Date: _____ Results: _____

Hepatitis B Series:

Date: _____ **Date:** _____ **Date:** _____

Tetanus **Date:** _____

Please submit supporting documentation of immunization records and lab results.

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.

Physician's Signature _____ **Date of Exam** _____

Physician's Printed Name _____

Address _____ **Phone** _____