LILY OF THE VALLEY EVOLVING (LOVE) - NURSE & ALLIED STAFFING 16701 MELFORD BLVD STE 400 BOWIE, MD 20715
PHONE: 443-329-9553. FAX: 443-227-4476. Email: ALLCLIN@LOVENURSINGSTAFF.COM

I, _____, do hereby authorize my healthcare practitioner to release any information acquired during my medical examinations to Lily of the Valley Evolving (LOVE)- Nurse and Allied Staffing, LLC. I also authorize Lily of the Valley Evolving (LOVE)- Nurse and Allied Staffing, LLC. To release any information received from my healthcare practitioner to the client facilities who may be interested in working with me.

I am answering the following questions as part of an annual screening for the symptoms of TB and COVID.

Did you ever have a Positive PPD ☐ NO ☐ YES, If yes, the date of the positive PPD: _____

Did you ever have a Positive COVID ☐ NO ☐ YES, If yes, the date of the positive COVID: _____

Do you have a persistent cough? ☐ NO ☐ YES

Are you coughing up blood? ☐ NO ☐ YES

Have you had a fever more than 3 days? ☐ NO ☐ YES

Have you had Unexplained weight Loss? ☐ NO ☐ YES

Do you have a Chronic Fever? ☐ NO ☐ YES

Do you suffer from Chest pain? ☐ NO ☐ YES

Have you had a sudden loss of smell? ☐ NO ☐ YES

Have you had a sudden loss of taste? ☐ NO ☐ YES

Have you had sudden/unexplained fatigue? ☐ NO ☐ YES

If you answered yes to any of the above questions explain below:

Patient Signature: _____ Date: _____

Health Statement:
I have examined this patient and determined that this person is in good physical and mental health, free of communicable disease and able to function and perform all job duties without any physical limitations in their profession at full capacity. I further attest that this patient has been cleared to complete FIT testing.

Color Vision Screening: ☐ PASS ☐ FAIL Comment: _____

Basic Vision Screening: ☐ PASS ☐ FAIL Comment: _____

Practitioners Name: _____ **Licenses #:** _____

Practitioner Address and Phone Number: _____

_____

_____

Practitioner Signature: _____ **Date:** _____