EMPLOYEE EVALUATION OF COMMUNICABLE INFECTIONS

TO BE FILLED OUT BY EMPLOYEE:

Date:________________________ Time:________________________
Employee's Name:______________________________________
Department:___________________________________________ Job Class:__________
Phone (Home):________________________ (Work):________________________
Supervisor (Name):______________________________________
Complaint/Problem:____________________________________

Do you have Direct Patient Care: ☐ Yes ☐ No

TO BE FILLED OUT BY NP/MD:

EMPLOYEE COMPLAINT: (Check appropriate box)
☐ Fever and/or chills
☐ Acute skin eruption/rash
☐ Purulent wound drainage
☐ Jaundice (yellow skin or eyes)
☐ Red eye and/or drainage

☐ "Fever blister" / "Cold Sore" (Herpes) [Open sore on face or sore on hand [Herpetic whitlows]]
☐ Severe sore throat

Evaluation:____________________________________________________

PLAN:
☐ You may return to work at this time. If symptoms continue, you should see your personal physician.

☐ You may return to work if you have no contact with patients or with the preparation and distribution of food.

☐ DO NOT return to work at this time. You need to get further evaluation and clearance of this problem by your personal physician.

Signature of Nurse Practitioner/M.D.

** NOTE TO EMPLOYEE:** The purpose of this evaluation is to screen for infections or communicable conditions and to determine whether you may work today. If you feel that you need further medical care, please contact your personal physician.