

PHYSICIAN'S STATEMENT

TRAVELER SECTION

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I _____, acknowledge and understand that the Company and its client facilities require
Traveler name (please print)
medical documentation reasonably necessary to make decisions regarding my employment. I agree to provide all requested medical documentation to the Company or, in the alternative, to provide my physician authorization to release requested documentation to the Company. I authorize the Company to share requested medical documentation with the Company's affiliates and client facility(ies) to which I am assigned. Neither the Company nor its client facility(ies) will further disclose medical documentation released pursuant to this authorization, unless further expressly authorized by me or required by law. This authorization shall become effective immediately and shall remain in effect for one (1) year. I understand that I have the right to receive a copy of this authorization upon request.

I also hereby specifically authorize my physician to release medical documentation relevant to my allergy to latex products to the Company.

Signature of Traveler

Date

PHYSICIAN SECTION

A. Work Related Allergies (Including Latex Allergies)? (Required)

None (Go directly to Section D)

Type of allergy: (Complete All Sections)

POWDER (check degree of sensitivity and applicable symptoms below):

LATEX (check degree of sensitivity and applicable symptoms below):

OTHER (work related allergy only), Describe: _____

Degrees of Sensitivity:

Irritant contact dermatitis

Allergic contact dermatitis (type IV)

IgE-mediated hypersensitivity (type I)

Symptoms:

Dry, crusty lesions usually limited to area where the skin came into contact with latex

Symptoms:

- Skin lesions or crusty thickened appearance of the skin
- Rash that may persist for 7 - 10 days, usually limited to area where the skin came into contact with latex
- Pruritus
- Erythema
- Vesicular lesions
- Eczema
- Contact Urticaria

Symptoms:

- Immediate reactions within 30 minutes to 1 hour from exposure which may affect:
 - Skin
 - Respiratory tract
 - Gastrointestinal tract
- Skin manifestations including flushing, swelling, and contact urticaria
- Runny eyes and nose
- Symptoms of asthma
- Diarrhea and/or vomiting

B. Exposure limits (Check one): Direct Contact

Environmental

C. Accommodations/Limitations: (Required - Check all that apply)

Latex Free Gloves Powder Free Gloves Latex & Powder Free Gloves

GLOVE SIZE: _____

Other (Please explain any other necessary accommodations): _____

A C C O M M O D A T I O N S M U S T B E
C H E C K E D O R C O M P L E T E D

D. Physician Statement of Ability to Work: (Section A must be completed)

I have examined and obtained a current history on the individual named above; and to the best of my knowledge, he/she is in good physical and mental health, is free of any communicable diseases, has no physical limitations, and is able to function in his/her professional discipline and specialty on a full-time basis at full capacity without any accommodations (including for allergies) or with the accommodations listed above.

E. Physician Information

Printed Name

MD PA DO NP Other: _____

(Explain)

Signature

Phone Number

Date