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

APPLICANT[1] INFORMATION – to be completed by CCS

Date ______________________ GHC member no. ______________________

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 ____

Visual examination of all skin likely to come into contact with children during routine care is free of signs of communicable disease or infection: ☐ Yes ☐ No

Does applicant report any past occurrence of symptoms of MRSA infection? ☐ Yes ☐ No

If yes, describe where and recommended treatment:

____

Does applicant report any past occurrence of symptoms of communicable disease or infection? ☐ Yes ☐ No

If yes, describe treatment: ____

TB skin test: ☐ Negative ☐ Positive

Comments: ____

Provider signature ______________________ Date ______________________

[1] Applicant who has been given a conditional offer of employment.

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.