CARING
PROFESSIONALS, INC.
LICENSED HOMECARE AGENCY

QUEENS
70-20 Austin Street, Suite 135
Forest Hills, NY 11375

BROOKLYN
1417 Sheepshead Bay Road,
Brooklyn NY 11235

1400 Avenue Z, 3rd floor
Brooklyn, NY 11235

BRONX
1231 Lafayette Ave, 2nd Floor
Bronx , NY 10474

INTAKE
T: 800-706-6568 • F: 347-694-4858

CDPAP REQUIRED DOCUMENTS FOR REGISTRATION

• STATE ID & SOCIAL SECURITY CARD

- ☐ *US passport*
- ☐ *Green Card*
- ☐ *Employment Authorization*
- ☐ *Valid Driver License.*

• PHYSICAL FORM: MUST INCLUDE

- ☐ *Date*
- ☐ *Doctor's signature*
- ☐ *Doctor's Stamp.*
- ☐ PPD
- ☐ Chest X-Ray *(only if the PPD is POSITIVE)*

• LAB WORKS

- ☐ RUBELLA
- ☐ RUBEOLA
- ☐ FLU VACCINE (optional)

• DIRECT DEPOSIT

- ☐ *A personal check or Direct Deposit print out from the bank.*

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CARING ASSISTANTS PHYSICAL EXAMINATION

NAME_____ PHONE_____ TODAY'S DATE_____

ADDRESS_____

I. Past Medical/Psychological History

NO	YES		NO	YES	
☐	☐	Tuberculosis:	☐	☐	Epilepsy or seizure disorder:
☐	☐	Diabetes:	☐	☐	Drug alcohol abuse or addiction:
☐	☐	Heart or Cardiovascular Disease:	☐	☐	Psychiatric or Behavioral Disorder:
☐	☐	Hypertension:			Other: _____
☐	☐	Cancer:			Are you now taking medications?
☐	☐	Kidney Disease:			If so, for what? _____
☐	☐	Allergies: If yes, state: _____			_____
		_____			_____

EXAMINER: PLEASE COMPLETE THE FOLLOWING:

II. Mandatory Immunizations & Lab tests Exact titre number must be given as requested.

PPD (MANTOUX) Date Given_____ Date Read_____ Results: NEGATIVE_____mm POSITIVE_____mm

WHOLE BLOOD ASSAY TEST FOR T.B. Alternative to PPD testing: Date Drawn:_____ Results:_____ (NEGATIVE/POSITIVE)

CHEST X-RAY (Mandatory only if PPD/blood. Assay is positive) Date:_____ Results:_____

RUBELLA Titre:_____ Date:_____ Results: ☐Immune ☐Not Immune RUBELLA VACCINE_____ IF NEEDED

RUBEOLA *(not needed if born before 1957)* Titre:_____ Date:_____ Results: ☐Immune ☐Not Immune

RUBEOLA VACCINE: 1ST_____ 2ND_____

HEPATITIS B: ☐Immune ☐Refusal ☐Immunization Contraindicated | Vaccine Dates: _____ , _____ , _____

III. LAB TESTS: URINALYSIS: _____ _____ CBC: _____ _____

IV. REVIEW OF SYSTEMS BY EXAMINER:

Head/Neck:_____ EENT:_____ Resp. :_____ Cardiovasc.:_____ Abd-GI:_____ GU:_____

Muse–skel:_____ Neuro:_____ Endocrine:_____ Skin:_____ Height:_____ Weight:_____

V. MEDICAL EXAMINER

I hereby certify that the above named patient does not have any limitations for employment in the health care field, and contact with patients and other staff. There is no health impairment present that is of potential risk to the employee, patient, family, or other employees, or that may interfere with the performance of duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

PHYSICIAN'S SIGNATURE:_____ PHYSICIAN'S NAME (PRINT)_____

Address:_____ Phone:_____

(PLEASE USE PHYSICIAN'S STAMP)