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**Communicable Disease Screen  
Letter to Health Care Provider**

Dear Health Care Provider,

Our agency provides personal care services to elderly and disabled individuals. As such, we are required by regulation to provide for a communicable disease screen for our employees.

Our staff registered nurse has reviewed an initial employee communicable disease screen questionnaire and has determined that the employee below should receive a communicable disease screen from a health care provider.

Please note that the screening should assess for tuberculosis and **clinically apparent** communicable diseases such as hepatitis, measles, meningitis, pertussis, small pox, chickenpox, and HIV/AIDS. Please note that with the exception of tuberculosis, no specific testing is required and should not be performed as apart of this screen. A tuberculosis test may be conducted, however, all other potential communicable disease types must be determined based upon clinical observation only.

Please either sign below that the employee is free of clinically apparent communicable disease or provide the employee with other documentation stating such.

The screen may be conducted by a physician, physician assistant or a registered nurse.

Employee Name: \_\_\_\_\_

Health Care Facility: \_\_\_\_\_

I certify that the above individual has been screened for tuberculosis and is free of **clinically apparent** communicable disease.

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Physician, Physician Assistant or Registered Nurse Signature

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Date