Health Clearance Form for Health Care Providers Working in Missouri Long-Term Care Facilities (specifically Assisted Living Facilities and/or Residential Care Facilities)

Patient Name: _____

Date of Birth: _____

Date of Physical Examination: _____

_____ I have examined the above-named patient and find his/ her /their health is such that he/ she/them is physically and emotionally able to work in a long-term care facility. If the patient has any limitations affecting their ability to work in a long-term care facility I have indicated those limitations below in accordance with 19 CSR 30-86.047(20) and 19 CSR 30-86.042(15).

The above patient has the following physical and/or emotional limitations which may affect his/ her/ their ability to work in a long-term care facility:

_____

_____

_____

_____

Physician / NP / PA Signature: _____

Physician / NP / PA Printed Name:: _____

Clinic/ Practice Name: _____

Date: _____

Contact Phone Number: _____