HUMAN RESOURCES
Phone: 425-285-1201
Fax: 866-503-4090 Toll free
E-mail: info@annexaps.com

ANNUAL HEALTH STATEMENT

Complete all portions of this form and return to us by mail or fax.

Last Name _____ First _____ Employee ID _____ Date _____

Since completing your last Annexa Health Statement (or in the last year) have you experienced any of the following:

Alcohol abuse	❑ Y	❑ N	Hay fever	❑ Y	❑ N	Pneumonia	❑ Y	❑ N
Allergies	❑ Y	❑ N	Hepatitis A	❑ Y	❑ N	Psychological condition	❑ Y	❑ N
Arthritis	❑ Y	❑ N	Hepatitis B	❑ Y	❑ N	Rheumatism	❑ Y	❑ N
Asthma	❑ Y	❑ N	Hernia	❑ Y	❑ N	Seizures	❑ Y	❑ N
Back strain	❑ Y	❑ N	High blood pressure	❑ Y	❑ N	Sinus problems	❑ Y	❑ N
Back surgery	❑ Y	❑ N	Immune system disorder	❑ Y	❑ N	Skin disease	❑ Y	❑ N
Broken bones	❑ Y	❑ N	Jaundice	❑ Y	❑ N	Small pox	❑ Y	❑ N
Bronchitis	❑ Y	❑ N	Kidney disease	❑ Y	❑ N	Sprains	❑ Y	❑ N
Cancer	❑ Y	❑ N	Kidney stone	❑ Y	❑ N	Stomach disorders	❑ Y	❑ N
Cardiovascular trouble	❑ Y	❑ N	Liver disease	❑ Y	❑ N	Tuberculosis	❑ Y	❑ N
Diabetes	❑ Y	❑ N	Malaria	❑ Y	❑ N	Urinary tract infection	❑ Y	❑ N
Dislocations	❑ Y	❑ N	Mental condition	❑ Y	❑ N	Ulcers; peptic	❑ Y	❑ N
Epilepsy	❑ Y	❑ N	Migraine headaches	❑ Y	❑ N	Venereal disease	❑ Y	❑ N
Fainting spells	❑ Y	❑ N	Nervous condition	❑ Y	❑ N			

If you answered yes to any of the above, please explain. Use additional sheet if necessary.

_____

_____

Since completing your last Annexa Health Statement (or in the last year) has any of the following changed:

Allergies	Immunizations	TB Status	Physician Designation
Report known:	Tetanus: ❑ Vaccine ❑ Booster	Date of last PPD:	Name:
	Gamma Globulin: ❑ Y ❑ N	Month: Year:	Address:
	Hepatitis B Immune Globulin: ❑ Y ❑ N	Date of last CXR performed:	
	Series completed: ❑ Y ❑ N	Month: Year:	
	Date:		Telephone:

Health Clearance

The date of my last physical was (month/year): _____

The name and contact information of the physician and/or facility that performed the physical:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____

Do you have any physical condition which might limit your ability to perform within your scope of duties?	❑ Y	❑ N
Do you have any physical defects/limitations which preclude you from performing certain job/responsibilities?	❑ Y	❑ N
Is there pending, or have you applied for a pension, or compensation for any existing disability?	❑ Y	❑ N

I certify that the information set forth in this document is true and complete to the best of my knowledge and that I am the individual completing this form.

_____

Signature Date