



PPL CDPAP Personal Assistant Checklist

To work as a CDPAP Personal Assistant, you must complete the medical screening and provide required documentation demonstrating compliance with the program health requirements.

You may complete these requirements with your own health care provider (Primary Care Provider, Urgent Care, Occupational Health Clinic, etc.) or through The IMA Group.

Please use the checklist below to ensure all required items are completed and submitted.

MEDICAL EXAMINATION

Physical examination completed by a healthcare provider

LABORATORY RESULTS

MMR immunity documentation

- Positive MMR Titer results, OR
- Documentation of MMR Vaccination(s)

Tuberculosis (TB) screening

- PPD (Tuberculin Skin Test), OR
- QuantiFERON-TB Gold blood test

REQUIRED FORMS

PPL Participant Form completed and signed

Important Information: All medical examinations and laboratory results must be dated within the past 365 days to be accepted. Incomplete or missing documentation may delay processing and approval.

Submit Documentation to: The IMA Group via fax 1-518-218-9910 or email PPL@TheIMAGroup.com

To schedule an exam call: 1-844-540-1882

Questions about the CDPAP Program or Employment requirements? Contact PPL at 1-833-247-5346

Full Name: _____

PPL CASE ID: _____

TO BE COMPLETED BY PATIENT**General Release**

I understand this assessment is for employment purposes only and voluntarily consent to the examination and release of all information contained herein to my current or prospective employer and for other purposes that are permitted or required by law. I also understand that this assessment is not a substitute for a comprehensive annual check-up by my own physician.

全面讓渡

我明白這項評估是為了就業目的。我同意此處所包含的所有信息准予發表給我的現任或未來的僱主以及在法律規定/允許下作其他用途。我也明白這種評估是不能代替一個全面的年度體檢。

General De Estreno

Entiendo que esta evaluación es para fines de empleo y voluntariamente su consentimiento para el examen y la divulgación de toda la información contenida en este documento a mi empleador actual o futuro y para otros propósitos que sean permitidos o requeridos por la ley. También entiendo que esta evaluación no es un sustituto de un año completo chequeo por mi propio médico.

Signature (Firma) (簽名)_____
Date (Fecha) (日期)

Full Name: _____

PPL CASE ID: _____

PROCEDURE V/ROS: Vitals & Review of Systems

TO BE COMPLETED BY PATIENT: ****If N/A to everything below, initial here** _____

Last Menstrual Period: _____

Last Menstrual Period Comments (select which apply)?

- | | | | | |
|--|--|---------------------------------------|--|--|
| <input type="checkbox"/> N/A | <input type="checkbox"/> Irregular | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Menopause | If pregnant,
what is the
EDC?
_____ |
| <input type="checkbox"/> Perimenopause | <input type="checkbox"/> menstrual cycle | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Breastfeeding | |
| <input type="checkbox"/> Implanon | <input type="checkbox"/> Oophorectomy | <input type="checkbox"/> Depo-Provera | | |
| | <input type="checkbox"/> Unknown | | | |

Past Medical Illness: None Reported

- | | | |
|----------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Rubella | <input type="checkbox"/> Varicella (Chicken Pox) |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis | |

Past Medical History: None Reported

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Sickle Cell Trait or Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD/GI Disorder | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Stroke/CVS/TIA |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Injury: non-work |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Injury: work |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Headaches | <input type="checkbox"/> Motor Vehicle Accident | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> COPD or Lung Disease | <input type="checkbox"/> Hepatitis ___ (A, B, C?) | <input type="checkbox"/> Musculoskeletal disorder | _____ |
| <input type="checkbox"/> Diabetes Type I | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neck or lower back pain | _____ |
| <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> Hypercholesterolemia (Lipid Disorder) | <input type="checkbox"/> Neuropathy | _____ |

Past Surgical History: None Reported

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Liposuction | <input type="checkbox"/> Salpingectomy |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Lumpectomy | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Cataract removal | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Thyroidectomy |
| <input type="checkbox"/> C-section | <input type="checkbox"/> Laminectomy | <input type="checkbox"/> Ovarian cystectomy | <input type="checkbox"/> Tubal Ligation |

Date of last Surgery: _____

Other surgical notes:

Full Name: _____

PPL CASE ID: _____

Medications: None Reported Use Reported:

If Use Reported, list all medications:

Allergies:

- Seasonal Penicillin Environmental Perfume
 Nitrate Latex Animal/Pet Dander Smoke
 Vinyl Other/Drug:

Please list known allergies reactions:

Social History:

Tobacco Use:	<input type="checkbox"/> Denies present tobacco use	<input type="checkbox"/> Smoke several cigarettes per day	<input type="checkbox"/> Smokes >1 pack/day	<input type="checkbox"/> Social Smoker
Length of tobacco use:	<input type="checkbox"/> N/A	<input type="checkbox"/> 1-5 years	<input type="checkbox"/> 6-10 years	<input type="checkbox"/> >10 years
Alcohol Use:	<input type="checkbox"/> Denies use	<input type="checkbox"/> Consumes alcohol socially	<input type="checkbox"/> Consumes alcohol occasionally	<input type="checkbox"/> Consumes alcohol on a daily basis

****I attest that I am free from habit or addiction to alcohol, depressants, stimulants, narcotics, or other drugs or substances which may alter my behavior:**

YES Signature: _____ **Date:** _____

NO Signature: _____ **Date:** _____

EMPLOYEE NAME: _____

DATE OF BIRTH: _____

Test/Vaccination	Date	Immune	Non-Immune		Date	Negative	Positive
Rubella		<input type="checkbox"/>	<input type="checkbox"/>	Quantiferon Test (QFT)		<input type="checkbox"/>	<input type="checkbox"/>
Rubeola (Measels)		<input type="checkbox"/>	<input type="checkbox"/>	PPD (Step 1)		<input type="checkbox"/>	<input type="checkbox"/>
MMR Vaccine (1st Dose)				PPD (Step 2)		<input type="checkbox"/>	<input type="checkbox"/>
MMR Vaccine (2nd Dose)				If PPD/QFT positive - Chest Xray (** must state 'negative for active TB'*)		** must attach report	
** All labs (vaccinations as required) MUST be performed and reports MUST be attached **							

Tuberculosis Risk Assessment Screening

<input type="checkbox"/> Yes <input type="checkbox"/> No	Productive cough for more than 3 weeks	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fever, chills, or drenching night sweats for no known reason
<input type="checkbox"/> Yes <input type="checkbox"/> No	Coughing up blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Persistent shortness of breath
<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained fatigue for more than 3 weeks
<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest pain		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary or permanent residence (for >1 month) in a country with a high TB rate (i.e., any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of Prednisone >15mg/day for >1month) or other immunosuppressive medication
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had close contact with someone who has TB	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have documentation of prior TB tests, either a tuberculin skin test (TST) or an interferon-gamma release assay (IGRA) blood test and results
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a history of TB, LTBI, and treatment		

PHYSICAL EXAM							
Normal (NL)				Abnormal (AB)			
Vitals: B/P: _____		Pulse: _____		Resp: _____			
	NL	AB	Comment		NL	AB	Comment
General Appearance				Cardiac			
Skin				Abdomen			
Head, Eyes, Ears, Nose, and Mouth				Respiratory			
Neck				Neurologic			
Musculoskeletal / Gait				Psychiatric			
Genito-Urinary (including hernias)				Other body systems			

- This individual is free from health impairments which are of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs, or substances which may alter the individual's behavior
- This individual is able to work with the following limitations: _____
- This individual is not physically/mentally able to work (specify reason): _____

Clinician Signature: _____

Date: _____

Printed Name: _____

License Number & State: _____