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 together.

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 TB Testing (QuantiFERON or PPD) 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 1-518-971-8378 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 PA

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: _____

TO BE COMPLETED BY PA:

PROCEDURE V/ROS: Vitals & Review of Systems

****If N/A to everything below, initial here: _____**

Last Menstrual Period: _____
Last Menstrual Period Comments *(select which apply)*?

- ☐ N/A
- ☐ Irregular Menstrual Cycle
- ☐ Hysterectomy
- ☐ Menopause
- ☐ Perimenopause
- ☐ Oophorectomy
- ☐ Depo-Provera
- ☐ Breastfeeding
- ☐ Implanon
- ☐ Unknown
- ☐ Pregnancy
- ☐ If pregnant, what is the EDC? _____

Past Medical Illness: ☐ None Reported

- ☐ Measles
- ☐ Rubella
- ☐ Varicella (Chicken Pox)
- ☐ Mumps
- ☐ Tuberculosis

Past Medical History: ☐ None Reported

- ☐ Anemia
- ☐ Asthma
- ☐ Anxiety
- ☐ Cancer
- ☐ Cataracts
- ☐ COPD or lung disease
- ☐ Diabetes - Type I
- ☐ Diabetes - Type II
- ☐ Epilepsy
- ☐ GERD/GI Disorder
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Headaches
- ☐ Hepatitis (A, B, C) _____
- ☐ High Blood Pressure
- ☐ Hypercholesterolemia (Lipid Disorder)
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Motor Vehicle Accident
- ☐ Musculoskeletal Disorder
- ☐ Neck or Lower Back Pain
- ☐ Neuropathy
- ☐ Sickle Cell Trait or Disease
- ☐ Stroke/CVS/TIA
- ☐ Injury: Non-Work
- ☐ Injury: Work
- ☐ Other: _____

Past Surgical History: ☐ None Reported

- ☐ Appendectomy
- ☐ Breast Reduction
- ☐ Cataract Removal
- ☐ C-Section
- ☐ Cholecystectomy
- ☐ Hemorrhoidectomy
- ☐ Hysterectomy
- ☐ Laminectomy
- ☐ Liposuction
- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Ovarian Cystectomy
- ☐ Salpingectomy
- ☐ Tonsillectomy
- ☐ Thyroidectomy
- ☐ Tubal Ligation

Date of last Surgery: _____

Other Surgical Notes: _____

Full Name: _____

PPL Case ID: _____

TO BE COMPLETED BY PA:

Medications:	☐ None Reported	☐ Use Reported

If use reported, list all medications: _____

_____

_____

Allergies:	☐ None Reported	☐ None Reported

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

Please list known allergies reactions: _____

_____

_____

Social History:

Tobacco Use:	☐ Denies present Tobacco Use	☐ Smoke several cigarettes per day	☐ Smokes > 1 pack/day	☐ Social Smoker
Length of Tobacco Use:	☐ N/A	☐ 1-5 Years	☐ 6-10 Years	☐ > 10 Years
Alcohol Use:	☐ Denies Use	☐ Consumes Alcohol Socially	☐ Consumes Alcohol Occasionally	☐ 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:** _____

THE IMA Group

TO BE COMPLETED BY PROVIDER:

EMPLOYEE NAME: _____ **DATE OF BIRTH:** _____

Test/Vaccination	Date	Immune	Non-Immune		Date	Negative	Positive
Rubella		☐	☐	Quantiferon Test (QFT)		☐	☐
Rubeola (Measels)		☐	☐	PPD (Step 1)		☐	☐
MMR Vaccine (1st Dose)				PPD (Step 2)		☐	☐
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

☐ Yes	☐ No	Productive cough for more than 3 weeks	☐ Yes	☐ No	Fever, chills, or drenching night sweats for no known reason
☐ Yes	☐ No	Coughing up blood	☐ Yes	☐ No	Persistent shortness of breath
☐ Yes	☐ No	Unexplained weight loss	☐ Yes	☐ No	Unexplained fatigue for more than 3 weeks
☐ Yes	☐ No	Chest pain			
☐ Yes	☐ 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)	☐ Yes	☐ 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
☐ Yes	☐ No	Have you had close contact with someone who has TB	☐ Yes	☐ 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
☐ Yes	☐ 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:** _____