**Work Clearance & TB (PPD) Clearance**

**Applicants must have work clearance portion of this form completed in full. TB Clearance may be included on this form or attached separately.**

**Work Clearance**

Mr./Ms. (Applicant’s name): was seen by me on

(date): at (facility):

**He/she is in good physical condition and is able to participate in work related duties, without restrictions, that includes moderate to heavy lifting and walking/standing on his/her feet over an 8-hour time span.**

(Doctor’s signature): (NYC LIC#):

(Please Print Name): (Date):

**TB (PPD) Clearance**

Mr./Ms. (Applicant’s name): was seen by me on

(date): at (facility):

Applicant has received PPD (strength):

on Rt. forearm Lt. forearm

Please return on (date): so that test results can be read and recorded.

Given by (CLR): (date):

**\*\*Results** (positive): (negative):

(treatment):

**Release of Information Form**

I authorize **(*NAME OF AGENCY* to release information) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** to release my clinical information (psychiatric / medical / rehabilitation / social service / education / criminal history / drug and alcohol test results) to the program staff of **Project Comeback**. I understand that this information is used only to arrange services for me; is confidential; and is protected from disclosure. The extent or nature of information to be released is restricted to the following:

I understand that I have the right to cancel my permission to release information any time before it is released. I also understand that this consent to release information will expire when acted upon or 180 days from this date, whichever occurs first.

Client Name Client Signature Date

Service Provider Name Provider Signature Date

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Organization Name Organization Address

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Provider Phone Number Provider Email