



**Central State Community Services  
Annual Health Status Review**

**Pursuant to Adult Foster Care Group Home Licensing Rules R400.14205(6) &  
R400.15205(6)**

Name of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

Do you have any physical or mental condition, or are you taking any medication that negatively affects, or could negatively affect, your ability to meet the requirements of your job description (see attached)?

(Circle One)                      Yes                      No

Do you have any physical or mental condition, or are you taking any medication that negatively affects, or could negatively affect, the quality of care that you provide to our clients?

(Circle One)                      Yes                      No

Do you have any physical or mental condition, or are you taking any medication that negatively affects, or could negatively affect, the health of our clients?

(Circle One)                      Yes                      No

If you answered yes to any of the above questions you must have a satisfactory employee physical clearance completed by an occupational health clinic prior to returning to work. Please contact your Program Coordinator for guidance.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

Failure to answer the above questions correctly, to the best of your knowledge, could result in termination of your employment.