Free From Communicable Disease Statement

Updated 4-29-21

This Form must be Signed & Dated by a Physician OR Nurse Practitioner Within 5 days prior to admission to Congregational Home

Return Completed Form to:

Congregational Home
Attn: Admissions Dept
13900 W. Burleigh Rd Brookfield, WI 53005
Ph# 262-781-0550 Fx# 262-781-0559

Patient Name_____D.O.B._____

Planned Admission Date to Congregational Home_____

I have examined the above patient & certify that he/she is Free From Communicable Disease, including:

☑ **Free from active COVID within 5 days Prior to Admission to Congregational Home.**
(attach copy of COVID test done within 5 days prior to admission)

☑ **Free from active TB within 30 days Prior to Admission to Congregational Home.**

Signature_____Date_____
Physician or Nurse Practitioner

Print Name & Title_____

Clinic Address_____

_____

Clinic Phone#_____