NURSING AGENCY SELF HEALTH DECLARATION FORM	
Agency Name	
Address	
Phone	
Email	
Date	____ / ____ / _____
Applicant Details	
Applicant Name	
Position Applied For	
Date of Birth	
PPS Number (optional)	
Have you experienced any illness in the last 6 months? **Yes / No**	
If yes, please specify	
Are you currently on long term medications? **Yes / No**	
If yes, please provide details	
Vaccination Status	
FLU	Yes / No
COVID	Yes / No
I declare that I am in good health and fit to safely carry out my assigned duties.	
Signature	