Print Name _____ **DOB:** _____
Last Name First Name Middle Initial

Initial Uniform Health Assessment Form

Each applicant must have a history and physical performed prior to consideration or appointment as part of the credentialing and privileging process. It is assumed that the applicant's examining practitioner will directly review the health information with the applicant. This Uniform Health Assessment Form, which conforms to New York State Title 10 Health Code 405.3(b)(10)(11), has been developed by the Monroe County Medical Society, in conjunction with hospitals and other health care facilities in the Finger Lakes region. **Use of this form will enable the applicant's examining practitioner to complete a Uniform Health Assessment Form, only once, and then submit photocopies to relevant facilities/organizations.** This eliminates the need to complete multiple forms for multiple organizations.

This section to be completed by the applicant:

Permission by Medical/Dental Staff Applicant: I give permission to _____ to complete this history and physical examination form in accordance with New York State regulations for the health care facilities:

Applicant's Signature: _____ **Date:** ____/____/____

(***It is the responsibility of providers to forward a copy of this document to the requesting facilities***)

This section, through page 2, is to be completed by examining practitioner. The examination shall be of sufficient scope to ensure that no person shall assume his/her duties unless he/she is free from health impairment which is a potential risk to the patient or which might interfere with the performance of his/her duties. (Exam good for one year)

Medical History ____/____/____ Physical Examination Date ____/____/____

Medical: _____

Surgical: _____

Review of Systems: _____

Allergies *(including latex)*: _____

Medications: _____

Habits *(includes addiction to depressants, stimulants narcotics, alcohol or other drugs or substances which may alter the individuals behavior)* :

Weight: _____ **Height:** _____

Blood Pressure: _____

Vision: Corrected _____ **Uncorrected** _____

Lymph Glands: _____

Ears, Throat & Hearing: _____

Chest: _____

Heart: _____

Abdomen: _____

Back and Extremities: _____

Identified Health Problems That Are a Potential Risk to Patients or Practitioner: _____

Other: _____

Examining Practitioner's Statement: I have obtained an interim history, discussed a review of systems, and performed a physical examination on the above named practitioner. To the best of my knowledge, the above named is in good physical and mental health and is free from a health impairment, including a substance abuse problem, which is of potential risk to patients or which might interfere with the performance of the practitioner's duties, and the provision of quality patient care at each facility indicated on page one.

Examining Practitioner's Signature: _____ **Date:** ____/____/____

Examining Practitioner's Printed Name: _____

Examining Practitioner's Medical License #: _____

Address: _____

Telephone: (____)_____ **Fax:** (____)_____ **E-mail:** _____

Print Name _____ **DOB:** _____
Last Name First Name Middle Initial

Immunizations/Vaccines

RECOMMENDED IMMUNIZATIONS AND TESTS: INFORMATION IS REQUIRED

Hepatitis B vaccine: The **CDC STRONGLY RECOMMENDS** hepatitis B vaccination (includes 3 vaccines and post-vaccine titer) for all health care professionals. A signed declination form **must be completed** if this applicant declines vaccine.

Varicella History: If no confirmed disease history, serological test is required. If negative, vaccination with 2 Varicella vaccines is strongly recommended. A signed declination form **must be completed** if the applicant declines vaccine.

Tetanus-Diphtheria (initial series and booster every 10 years) OR Tdap: The CDC recommends that health providers who have direct patient contact should receive a single dose of Tdap as soon as feasible if they have not previously received it

Hepatitis B - 3 Vaccines & Post Vaccine TITER

Immunization #1 Date: ____/____/____ Immunization #2 Date: ____/____/____ Immunization #3 Date: ____/____/____

Post-Vaccine Titer: Date: ____/____/____ Result: _____

***Declination**: I decline the Hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk for acquiring Hepatitis B infection. In the future, if I continue to have occupational exposure to blood or potentially infectious materials and would like the Hepatitis B vaccine, I understand I may choose to receive the vaccine at any time in the future.

Declination Signature of Intern/Resident/Fellow: _____ Date: ____/____/____

Varicella (Chicken Pox) *(check one)*

❑ Varicella vaccine: ____/____/____ **OR** ❑ Have had chicken pox **OR** ❑ Positive antibody titer: Date: ____/____/____

*Declination: I decline the Varicella Vaccine and understand I am susceptible to chicken pox. I understand the risks of being susceptible to infections and blood borne diseases and decline immunization at this time. I understand I may choose to receive the vaccine at any time in the future.

Declination Signature of Intern/Resident/Fellow: _____ Date: ____/____/____

Tetanus-Diphtheria OR Tdap Immunization ____/____/____ ❑ Td ❑ Tdap

MEASLES /MUMPS/RUBELLA (MMR)

MMR (Measles, Mumps, and Rubella): 1st Vaccine: ____/____/____ 2nd Vaccine: ____/____/____

OR

Measles (Rubeola): 1st Vaccine Date: ____/____/____ 2nd Vaccine Date: ____/____/____ **OR** Positive Titer Date: ____/____/____

❑ Born before 1/1/57 *(proof of immunization is required only for individuals born after 1/1/57)* Results: _____

Mumps: Vaccine Date: ____/____/____ **OR** Positive Titer: Date: ____/____/____Results:_____

Rubella: Vaccine Date: ____/____/____ **OR** Positive Titer: Date: ____/____/____Results: _____

Print Name _____ **DOB:** _____
Last Name First Name Middle Initial

PPD Form

PPD/Mantoux/QuantiFERON *(required once every year-Please note, a BCG vaccine is not a contraindication for PPD)*

Tuberculin Skin Test (Mantoux) Requirements: Two TSTs (intradermal Mantoux skin tests) and interpretations are required, the first within one year of the second, the second within 3 months of starting residency program, unless history of past positive TST is reported. Tine tests are not acceptable. History of BCG does not meet the requirement-TST is still required.

❑ History of past positive PPD: Date of latest chest X-ray: ____/____/____ Results of X-ray: _____

First TST

Date of PPD placed: ____/___/____ Person Administering: _____
(signature) *(title)*

Date of PPD read: ___/____/____ Person Reading: _____
(signature) *(title)*

Result: _____mm (size of duration) Interpretation: ❑ Positive ❑ Negative

Second TST

Date of PPD placed: ____/___/____ Person Administering: _____
(signature) *(title)*

Date of PPD read: ___/____/____ Person Reading: _____
(signature) *(title)*

Result: _____mm (size of duration) Interpretation: ❑ Positive ❑ Negative

quantiFERON Date: Result _____

Examining Practitioner's Signature:_____ **Date:** ___/____/____

Examining Practitioner's Printed Name: _____

Examining Practitioner's Medical License #: _____

Address: _____

Telephone: (____)_____ **Fax:** (____)_____ **E-mail:** _____

Print Name _____ **DOB:** _____
Last Name First Name Middle Initial

Respirator Mask Form

N95-TB Protection Mask:

Brand: ❑ Tecnol ❑ 3M 8512 ❑ PAPR
Size ____

Other mask + size: _____

(*If you have previously been fit for the above models please provide certification document)*

Examining Practitioner's Signature:_____ **Date:** ___/____/____

Examining Practitioner's Printed Name: _____

Examining Practitioner's Medical License #: _____

Address: _____

Telephone: (____)_____ **Fax:** (____)_____ **E-mail:** _____