

Print Name _____
Last Name First Name Middle Initial

DOB: _____

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 applicant 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: _____

Other: _____

Examining Practitioner's Signature _____

Examining Practitioner's Printed Name _____

Address _____

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

Date:
9/28/2009

rev.

Print Name _____
Last Name First Name Middle Initial

DOB: _____

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 per guidelines**

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 & body fluids, I understand I may choose to receive the vaccine at any time.

Declination Signature of applicant: _____

Date: _____

Varicella (Chicken Pox)

Varicella vaccine: #1 Date: _____ #2 Date: _____

OR

Verification of history of Varicella disease by health-care provider.
(If unable to verify history, then do titer)

OR

Positive antibody titer: Date: _____

***Declination:** I decline the Varicella Vaccine at this time and understand that I am susceptible to chicken pox. I understand the contagion risks of being susceptible to Varicella infection and that I may choose to receive the vaccine at any time in the future.

Declination Signature of applicant: _____

Date: _____

Tetanus-Diphtheria OR Tdap

Immunization Date: _____ Td Tdap

N95-TB Protection Mask: Brand TecnoL 3M 8512 PAPR
Size _____

Other mask + size: _____

OSHA mandates a yearly fit test.

Examining Practitioner's Signature _____

Examining Practitioner's Printed Name _____

Address _____

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

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Rubella (must be documented by positive titer or date of vaccination)

Titer: Date: _____ Results: _____

OR

Vaccine: Date Received: _____ (1 dose of live vaccine given on or after the 1st birthday)

Measles (Rubeola) (only individuals born before 1/1/57 may self report disease)

Self reported disease Date if known: _____

OR

Titer: Date: _____ Results: _____

OR

Measles vaccine: (2 doses of live measles vaccine administered on or after the 1st birthday and at least 30 days apart with the second dose after 15 months old:

TB Status

Tuberculin Skin Test (TST) (yearly requirement) Please note, a BCG vaccine is not a contraindication for TST

Tuberculin Skin Test (Mantoux) Requirements: Two TST (Mantoux intradermal skin test) tests and interpretations are required, the first within one year of the second, the second within 3 months of appointment, 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 TST: Date of latest chest X-ray _____ Results of X-ray: _____

Date of 1st TST: _____ Result: _____ mm (size of duration) interpretation: Positive Negative

Date of 2nd TST: _____ Result: _____ mm (size of duration) interpretation: Positive Negative

QuantiFERON Date: _____ Result _____

Examining Practitioner's Statement: I the undersigned and designated primary care giver have completed this health assessment form with full knowledge and documentation in the medical record that this practitioner is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

Examining Practitioner's Signature _____

Examining Practitioner's Printed Name _____

Address _____

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

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