Office Use Only
Date Received:

_____ _____ _____

Last name, First Name (Printed) **Degree** **Date of Birth**

Annual Health Assessment Form

Each member must have an annual health review within 30 days of the previous year's exam. Health care providers must be in good physical and mental health, free from impairment of potential risk to patients or which might interfere with the performance of the practitioner's duties, exercise of clinical privileges and the provision of quality patient care.

This Uniform Annual Health Review Form, conforms to New York State Title 10 Health Code 405.3(b)(10)(11) Use of this form will enable the applicant's examining practitioner to complete an Annual Uniform Health Review Form, and then have the staff member submit the information to relevant facilities/organizations.

Staff Member Statement

Completed by the staff member:

Have there been any changes in your health status – physical or mental – in the past year, or since your last physical examination? ___ Yes ___ No If yes, please record the details on a separate sheet.

_____ _____

Staff Member's Signature **Date**

Examining Practitioner's Statement

Examining Practitioner's Statement: I the undersigned, a licensed healthcare Practitioner, 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 _____ Date _____

Examining Practitioner's Printed Name _____

Examining Practitioner's Medical License # _____

Address _____

Phone (____) _____ Fax (____) _____ Email _____

Please send this document to the URMC Medical Staff Office via email: MedicalStaffOffice2@urmc.rochester.edu, or fax it to (585)784-8367.

_____	_____	_____
Last name, First Name (Printed)	**Degree**	**Date of Birth**

Office Use Only
Date Received:

Annual Respirator Mask Form

N95-TB Protection Mask: **Brand:** __ Halyard __ Kimberly-Clark __ 3M 1870 __ MSA ½ face
__ 3M 1860 __PAPR

Size: _____

Other mask + size: _____

OSHA mandates a yearly fit test.

Examining Practitioner's Signature _____ Date _____

Examining Practitioner's Printed Name _____

Examining Practitioner's Medical License # _____

Address _____

Phone (____) _____ Fax (____) _____ Email _____

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Revised 3/5/21

Health Update Questionnaire

This **Health Update Questionnaire** is *only* required for providers with privileges at Strong Memorial Hospital and Highland Hospital

Last name:	**First name:**	**MI:**
Date of birth:	**Today's date:**	**BP:**

	Yes	No
1. Have you had any NEW allergies to medications, foods, etc.?		
Anaphylactic reaction		
GI symptoms		
Hives/urticaria		
Other:		
2. Have you had any significant health problems?		
Diabetes		
Thyroid disorder		
Hypertension		
Coronary artery disease		
Other:		
3. Have you had any health problems that may be related to your job?		
Dermatitis		
Back		
Carpal tunnel		
Other:		
4. Have you been prescribed any NEW medications? If Yes, please list:		
5. Have you been hospitalized in the past year? If Yes, please list date(s) and reason(s):		
6. Any condition that would interfere with the ability to perform your job that would be a risk to patients or other employees? Comments:		
7. Any past positive PPD results?		
Previous treatment? Date: Medications:		
Chest X-ray? If yes, results:		
Symptoms		
Cough, persistent, productive		
Fever		
Night sweats		
Weight loss		
Other:		
8. Since your last health assessment, have you had:		
History of temporary or permanent residence (for > 1 month) in a country with high TB rate (i.e. any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe)?		
Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with an TNF- alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone > 15mg/day for 1 month) or other immunosuppressive medication?		
Any known or suspected unprotected exposure to a person with active TB at a time when you were not wearing proper N-95 respiratory protection?		

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Last name:	First name:	MI:

	Yes	No
9. Do you have any other concerns or questions regarding TB?		
10. Have you been fit tested for a TB (N95) mask?		
Since your last update, have you had any notable changes in your facial appearance, such as change in weight plus or minus 20 lbs., dental surgery, facial hair or facial reconstruction surgery? Comments:		
11. Have you noted any problems in the fit of your mask or your ability to tolerate the mask? Comments:		
12. Do you use tobacco products?		
13. Do you feel threatened in your work area, or does your work environment present a risk to your safety? If yes, does this threat stem from:		
Patient		
Co- workers		
Visitors		
Other (describe)		
14. Does your work environment (equipment/room layout, isolation, clutter, etc.) contribute to a risk to your safety?		
15. If you answered "Yes" to question 13 and/or 14, would you want to be contacted by Security or Environmental Health and Safety (provide contact information)?		
Contact Information:		

Reviewed by:

Examining Practitioner's or Nurse Signature_____ Date _____

Examining Practitioner's or Nurse Printed Name _____

Examining Practitioner's or Nurse State License # _____

Address _____

Phone (____) _____ Fax (____) _____ Email _____

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