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

Office Use Only
Date Received:

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 to (585)784-8367.

Office Use Only
Date Received:

_____ _____ _____

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

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.

Reviewed by:

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 to (585)784-8367.

Health Care Personnel – TB Risk Assessment

Please complete this form and send to the Medical Staff Office of your primary UR Medicine facility as noted below.

For information regarding TB Screening and Testing of health care personnel, please access the CDC website: https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm

TB (Tuberculosis) Risk Assessment *(Required for all)*

1.	In the last 5 years, have you had a history of temporary or permanent residence (for > 1 month) in a country with a high TB rate (e.g., any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe)?	__Yes* __ No
2.	Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone > 15mg/day for > 1 month) or other immunosuppressive medication?	__Yes* __ No
3.	Within the past year, have you had any close contact with someone who has had infectious TB disease since your last TB test and/or risk assessment?	__Yes* __ No

TB (Tuberculosis) History *(If you answered "Yes" to any of the above TB Risk Assessment questions, please compete this section.)*

a)	Have you ever been exposed to TB?	__Yes* __ No
b)	Have you ever had, or do you have a TB infection or disease?	__Yes* __ No
c)	Have you ever had any prior treatment for TB infection or exposure?	__Yes* __ No
d)	Have you had a CXR (prior diagnostic testing) for TB?	__Yes* __ No
e)	Have you had a TST (tuberculin skin test) or otherwise known as PPD in the last year?	__Yes* __ No
f)	Have you had an IGRA blood test? T-Spot (QFT is an interferon-gamma (IFN-γ) release assay, commonly known as an IGRA modern alternative to skin test) in the last year?	__Yes* __ No
g)	Have you had a QuantiFERON-TB Gold (QFT) blood test that aids in the detection of Mycobacterium tuberculosis, the bacteria which causes tuberculosis (TB) in the last year?	__Yes* __ No

h) Have you experienced any of the following symptoms in the past year?

- A productive cough for more than 3 weeks? __Yes* __ No
- Hemoptysis (coughing up blood)? __Yes* __ No
- Unexplained weight loss? __Yes* __ No
- Fever, chills or night sweats for no known reason? __Yes* __ No
- Persistent shortness of breath? __Yes* __ No
- Unexplained fatigue? __Yes* __ No
- Chest pain? __Yes* __ No

Provider Information:

Practitioner Printed Name _____ Date _____

Practitioner Signature _____

Phone (____) _____ Email _____

Submit this form: Please fax or email this completed form to the Medical Staff Office at your primary UR Medicine facility.

	Phone	Fax	Email
FF Thompson Hospital	(585) 396-6665	(585) 396-6534	FFTHMedicalStaffOffice2@URMC.Rochester.edu>
Highland Hospital	(585) 784-8822	(585) 784-8367	MedicalStaffOffice2@urmc.rochester.edu
Jones Memorial Hospital	(585) 596-4002	(585) 596-4005	Teri_Monroe@urmc.rochester.edu
Nicholas H. Noyes Memorial Hosp	(585) 335-4324	(585) 335-4333	Hiedi_Eaton@urmc.rochester.edu
St James Hospital	(607) 385-3922	(607) 385-3195	Kelly_Grillo@urmc.rochester.edu
Strong Memorial Hospital	(585) 784-8822	(585) 784-8367	MedicalStaffOffice2@urmc.rochester.edu

** If your answer is "yes" to any of the above questions, follow-up will be required. Please refer to the Medical Staff Office at your primary UR Medicine facility for further instructions.*

Revised 09/07/2021