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 _____

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

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Annual Respirator Mask Form

N95-TB Protection Mask: **Brand:** __ Halyard __ 3M 8512 __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 _____

_____ _____ _____

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

Office Use Only
Date Received:

Annual TST/PPD Form

Tuberculin Skin Test (TST) ***unless there is a history of a past positive TST. Please note, a BCG vaccine is not a contraindication for TST. Repeat CXR is NOT required unless suggestive symptoms***

Date of TST: _____

Date of Result: _____ __Negative __Positive Result: ___ mm (size of duration) interpretation

History of past positive TST: Date of last chest X-ray _____

Results of X-ray: _____

Preventative treatment for positive TST __ No __Yes If yes, specify _____

Any symptoms of active tuberculosis __ No __Yes If yes, specify _____

Interpreting practitioner: _____ Result: _____

Examining Practitioner's Signature_____ Date _____

Examining Practitioner's Printed Name _____

Examining Practitioner's Medical License # _____

Address _____

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

Please fax to URMC Medical Staff Office at (585)784-8367 *or* email to MedicalStaffOffice2@urmc.rochester.edu Revised 6/16/14, 01/02/20