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, 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 a Uniform Health Assessment Form, and then submit the information to relevant facilities/organizations.

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)

To be completed by the Applicant:

Medical History: ____/____/____

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):

_____

_____

_____

To be completed by the Examining Practitioner:

Physical Examination Date: ____/____/____

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.

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 3/1/21

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

IGRA Date: _____ Result _____

☐ QFT ☐ T-Spot

Examining Practitioner's Signature_____ Date ____/____/____

Examining Practitioner's Printed Name _____

Examining Practitioner's Medical License # _____

Address _____

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

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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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