Occupational Health Services
222 Station Plaza North Room 515, Mineola NY 11501
Phone: 516-663-2534 Fax: 516-663-1197

Name: _____
Address: _____

NYU Winthrop Hospital's health and immunization standards are based on Nassau County and New York State Department of Health requirements and recommendations. ***If you do not provide necessary documentation, you may not begin as scheduled.*** **OHS does not save any of your documentation. In the event that you need to renew your clearance, you must come back to our office with all necessary documentation.**

1) **Immunity: Please have your practitioner fill out ONE section below. Alternatively, you may provide a proof of immunity via titer or an electronic medical record.**

Dates:	Dates:	Dates:
MMR #1 _____	**Measles Vaccine** **#1 _____ #2 _____**	**Measles Titer Results** **_____**
MMR #2 _____	**Mumps Vaccine** **#1 _____ #2 _____**	**Mumps Titer Results** **_____**
	Rubella Vaccine **_____**	**Rubella Titer Results** **_____**
	Varicella Vaccine **#1 _____ #2 _____**	**Varicella Titer Results** **_____**

2) **Tuberculosis Screening:** Proof of ONE (1) **PPD skin test** administered and evaluated **within** current calendar year **OR** proof of an **IGRA blood test (attach report)**.

Date PPD Placed: _____ / _____ / _____ **Reaction:** _____ **mm duration and Result:** _____

Date PPD Evaluated: _____ / _____ / _____ **Evaluated by:** _____

NOTE: *If you have or ever had a* ***POSITIVE reaction****, you are required to submit complete documents: date PPD placed, date PPD read (or positive IGRA) and reaction, signed by an evaluator, along with a copy of chest x-ray report post positive PPD result. In addition, documentation of a negative TB symptom review must be provided on an annual basis after the positive reaction (signed and dated by a practitioner).*

Name: _____

TB Symptom Review Date: _____ / _____ / _____ ***TB Symptom Review Result:*** _____

Practitioner Signature: _____

3) **Tdap Vaccine:**
Date Received: _____ / _____ / _____ Administered by: _____

4) **Proof of FLU SHOT:** (Starting Oct 1st through end of NYS Flu Season)

Date Received: _____ / _____ / _____ Administered by: _____

Practitioner Signature: _____

5) **Practitioner Certificate:** (MUST BE DATED WITHIN 12 MONTHS)

Have your practitioner fill out this section or provide documentation stating you are in good health.

I have performed a physical examination of sufficient scope to ensure that the above mentioned person is free from health impairment which is of potential risk to the patient or which might interfere with performance of his/her duties, including the habituation nor addition to depressants, stimulants, narcotic, alcohol or other drugs or substance which may alter the individual's behavior [Per N.Y.S. Code 405 3 (b)].

Practitioner Signature: _____ **Date:** _____ / _____ / _____
Practitioner Name (Print)**:** _____ **Phone:** ____ - _____ - _____
Address: _____

Individual/Student/Faculty Attestation: (MUST BE DATED WITHIN 12 MONTHS)

I attest to the fact that I am free from health impairment which is of potential risk to the patient of which might interfere with the performance of my duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter my behavior. (Per N.Y.S. Code 405.3 [b10]). I understand that the falsification or misrepresentation of any of the information or the failure or neglect to disclose any of the information may be grounds for termination from this program, regardless of when such falsification, misrepresentation, failure or neglect may be discovered.

Individual/Student/Faculty Signature: _____
Date: _____ / _____ / _____

***OHS WILL ISSUE A CLEARANCE FORM WHEN ALL REQUIREMENTS ARE MET.**
***OBSERVATION/NON-EMPLOYEE = contracted worker, student, temp agency referral, vendor, rotation resident, intern or any personnel not on NYU Winthrop Hospital payroll.**
***In the event that you need to renew your clearance, you must come back to our office with all necessary documentation.**