

**Certificate of Health Statement**  
**For Non-Employee Medical Clearance**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_  
 Contact Phone (Cell) Number: \_\_\_\_\_ Email: \_\_\_\_\_  
 Job Title or Activity: \_\_\_\_\_ Start Date: \_\_\_\_\_ Exit: \_\_\_\_\_  
 Anticipated Patient Contact: \_\_\_\_\_

**FROM: (Current Organization)**

**TO: (Upstate)**

Employer or Program	Upstate Dept. or Program
Contact Person from Organization	Contact Person at Upstate
Contact Person Phone No.	Upstate Contact Phone No.

**In the past year, have you had:**

- Contagious or communicable illness? .....  Yes  No
- Skin infection or open (non-healing) wounds? .....  Yes  No
- Recent weight loss, cough, fever, and or night sweats? .....  Yes  No

Detail any "Yes" responses: \_\_\_\_\_

**To the best of my knowledge the information above is accurate and truthful.**

**Signature:** \_\_\_\_\_

To be completed by Health Care Provider	
<b>Required:</b>	
Date of physical exam or health assessment (within one year): _____	
Tuberculin Mantoux Skin Test: (TST) (required within 1 year of assignment)	
Date Admin.: _____	Manufacturer: _____ Lot/Exp.No.: _____
Date Read: _____	Reaction (mm): _____
Chest X Ray if positive TST within 1 year of assignment: (Report must be attached):	
Date: _____	Date: _____
Rubella (German Measles): IgG antibody titer (blood test):	Date: _____ Result: _____
Rubeola (Measles): IgG antibody titer (blood test):	Date: _____ Result: _____
<b>Recommended (not required):</b>	
Mumps: IgG antibody titer (blood test):	Date: _____ Result: _____
Varicella (Chicken Pox): IgG antibody titer (blood test):	Date: _____ Result: _____
Varicella Disease History: <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Verification of Information by Health Care Provider:** I have determined that this individual is free from health impairment, which may pose potential risk to Upstate patients or personnel.

**Signature:** \_\_\_\_\_ **Stamp:** \_\_\_\_\_

**Date:** \_\_\_\_\_

ESH Clearance: \_\_\_\_\_