

Short Term Health Statement

For Non-Employee Medical Clearance

(If affiliation/visit is less than 3 days in duration)

Name: _____ DOB: _____ Date: _____
 Contact Phone (Cell) Number: _____ Start Date: _____ Exit Date: _____
 Job Title or Activity: _____ Patient contact anticipated? _____
 E-mail address: _____

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:

1. contagious or communicable illness? Yes No
2. skin infection or open (non-healing) wounds? Yes No
3. 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: _____

Return form to:

Employee/Student Health, Jacobsen Hall
 Upstate Medical University Health Care Systems
 750 East Adams St. Syracuse, NY 13210
 Phone: 315-464-4260
 Fax: 315-464-5471

ESH: _____