



Employee / Student Health

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State University of New York

Upstate Medical University

SHORT TERM HEALTH STATEMENT (3 days or less) ALL SPACES MUST BE COMPLETED

Name: _____ Sex M F Date of Birth: _____
 Institution or Agency: _____ Social Security #: _____
 Contact Person: _____ Phone Number: _____
 Dept. Location: _____ Hospital Other
 Contact Person: _____ Phone Number: _____
 Position: _____ Start Date: _____ Exit Date: _____
 Local Address: _____ Telephone #: _____

It is the responsibility of all observers to be free of communicable disease, which could potentially jeopardize the health of patients and personnel. Please read and sign the following statement.

1. Do you now have or have you been treated for any contagious illness within the last year? Yes No
2. Do you have any type of skin infection or open (non-healing) areas on your body surface? Yes No
3. Have you had any recent weight loss, cough, fever and/or night sweats? Yes No
4. Is there any additional pertinent information regarding your health? Yes No
5. How would you describe your health? _____
6. Please respond to any "yes" answers: _____

I attest that I am free of any communicable disease, including respiratory illness and/or skin infection, to the best of my knowledge. (Parent or legal guardian must sign for those under 18 years of age.)

Signature Date

RETURN TO: Employee/Student Health Office, Jacobsen Hall,
SUNY Upstate Medical University,
750 East Adams Street. Syracuse, NY, 13210.

FOR HEALTH SERVICES

Reviewed by: _____
 Date: _____
 Comments: _____