



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: \_\_\_\_\_