750 East Adams Street
Syracuse, NY 13210

Employee/Student Health

Tel 315.464.4260
Fax 315.464.5471

www.upstate.edu

State University of New York

Upstate Medical University

To: Medical Staff Applicants

From: K. Bruce Simmons, MD
Director, Employee/Student Health

Re: Requirements for Medical Clearance

The New York State Department of Health requires that complete history and physical, proof of immunity for rubella and rubeola, and surveillance for tuberculosis be submitted for medical clearance prior to granting of medical staff privileges.

Requirements for Medical Clearance:

- History and physical exam completed within 6 months of applying for privileges.
- Rubella Titer – a copy of the lab report must be provided.
- Rubeola Titer (if born 1/1/57 or later) – a copy of the lab report must be provided.
- Tuberculin Skin Test (PPD) – Must be placed and read within 6 months of applying for privileges.
- Chest x-ray – If prior tuberculin skin test has been positive. This must be done within 6 months of applying for privileges. A copy of the official report must be provided

Medical forms are viewed only by the medical personnel of Employee/Student Health.

All required documents should be submitted at one time by mail or fax to:

Employee/Student Health
Upstate Medical University
750 E. Adams Street
Syracuse NY 13210

Telephone: 315.464.4260
Fax: 315.464.5471

State University of New York
Upstate Medical University

Immunization Record

Employee/Student Health • 750 East Adams Street • Syracuse, New York 13210

Last Name ____ First ____ Middle Initial ____ Date of Birth ____ Today's Date ____

The New York State Health Code, Section 405.3, requires documentation of immunity for rubella and rubeola. Surveillance for tuberculosis is mandatory. Tuberculin skin test within 6 months of medical staff application is required. Prior BCG administration does not negate the need for TST. Chest x-ray within 6 months is required if TST is known to be reactive (positive).

Rubella: Antibody Titer: (copy of the lab report is required)

Date: ____ Result: ____

If titer negative, date of immunization: ____

Rubeola: Antibody Titer: (copy of the lab report is required)

Date: ____ Result: ____

If titer negative, date (s) of immunization: ____

Tuberculin Skin Test (PPD) ***Required within 6 months of assignment***

TST: Date placed: ____ Manufacturer: ____ Lot#: ____

Date read: ____ Result: ____ mm

If TST Positive: Chest x-ray *within 6 months* of assignment is required

Date: ____ Result: ____ (enclose a copy of report)

Varicella: (chickenpox): One of the following indicators of immunity is required:

Varicella immunizations received:		Varicella titer done:		History of having varicella :
Date: #1: ____ Date: #2: ____	**OR**	Date: ____ Immune: ☐ Yes ☐ No Enclose Copy of Laboratory Report	**OR**	☐ Yes ☐ No

Hepatitis B Vaccine: series completed? ____ ☐ **Yes**

Send or fax the completed medical history, physical examination, proof of immunity (including titer lab reports), and tuberculin skin test or chest x-ray result to Employee/Student Health. Medical clearance will be issued when all medical information has been submitted and approved.

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S t a t e U n i v e r s i t y o f N e w Y o r k

Upstate Medical University

Medical Staff History and Physical

Last Name ____ First ____ Middle Initial ____ Sex ____ Date of Birth ____ Today's Date ____

Local Address (No. and Street) ____ City ____ State ____ Zip ____ Social Security Number ____

Email Address ____ Phone Number ____ Job Title ____ Department/Unit ____

Personal Health History

Have you **EVER** had, or do you have, any of the following? If YES, please specify by number and provide an explaination.

	No	Yes
1. Chicken pox or shingles	☐	☐
2. Measles	☐	☐
3. Mumps	☐	☐
4. Skin problems or chronic rash	☐	☐
5. Eye problems	☐	☐
6. Hearing loss or ear problems	☐	☐
7. Chronic cough	☐	☐
8. Asthma	☐	☐
9. Shortness of breath	☐	☐
10. Lung problems	☐	☐
11. Tuberculosis or positive TB skin test	☐	☐
12. Chest pain	☐	☐
13. Heart trouble/attack	☐	☐
14. Palpitations/irregular heart beat	☐	☐
15. Heart murmur	☐	☐
16. High blood pressure	☐	☐
17. Stroke or paralysis	☐	☐
18. Stomach or intestinal problem	☐	☐
19. Liver disease/hepatitis	☐	☐
20. Kidney disease	☐	☐
21. Weight change	☐	☐
22. Thyroid problems	☐	☐
23. Shoulder/elbow/wrist/hand pain	☐	☐
24. Numbness/tingling of arms or hands	☐	☐

	No	Yes
25. Broken bones	☐	☐
26. Bone or joint problems	☐	☐
27. Arthritis/gout	☐	☐
28. Back pain/injury	☐	☐
29. Numbness/tingling legs or feet	☐	☐
30. Knee pain/injury	☐	☐
31. Foot pain/injury	☐	☐
32. Neck pain/injury	☐	☐
33. Loss of limb	☐	☐
34. Severe headaches	☐	☐
35. Dizziness or fainting	☐	☐
36. Epilepsy or seizures	☐	☐
37. Severe weakness or tiredness	☐	☐
38. Depression or anxiety	☐	☐
39. Emotional or psychiatric problems	☐	☐
40. Drug or Alcohol dependency	☐	☐
41. Eating disorder	☐	☐
42. Bleeding or blood disorder	☐	☐
43. Immune suppression	☐	☐
44. Chronic/recurrent infection	☐	☐
45. Tumor/cancer	☐	☐
46. Anemia	☐	☐
47. Diabetes	☐	☐
48. Any other illness not listed	☐	☐

NAME: ______________________________

Please Check **EACH** Item, If YES, please specify by number and provide an **EXPLAINATION**.

	Question	No	Yes
1.	Are you on any medications	☐	☐
2.	Do you have any allergies to medication	☐	☐
3.	Do you use other drugs	☐	☐
4.	Do you use alcohol	☐	☐
5.	Refused as a blood donor	☐	☐
6.	Do you smoke cigarettes	☐	☐
7.	Have you ever been hospitalized	☐	☐
8.	Have you ever had surgery	☐	☐
9.	Have you ever received treatment or counseling for psychiatric or emotional illness	☐	☐
10.	Do you have allergies to certain chemicals, dust, animals, or animal products (animal dander, bedding waste)	☐	☐
11.	Have you ever been refused employment for health reasons	☐	☐
12.	Do you have visual, hearing or other physical limitations	☐	☐
13.	Are you unable to assume certain body positions	☐	☐
14.	Are you unable to perform certain motions	☐	☐
15.	Is there any reason you cannot fully perform all duties that your employment or volunteer work will require on any shift	☐	☐
16.	Have you ever had a work related injury or illness	☐	☐
17.	Have you ever had:		
	a) needlestick/blood or body fluid exposure	☐	☐
	b) rash or symptoms related to glove use	☐	☐

I certify that the information documented above is true and complete. I understand that misrepresentation or omission of facts called for may prevent or result in termination of medical staff privileges if granted. To the best of my knowledge, I do not have any physical or mental health impairment which is of potential risk to patients or that might interfere with the performance of my duties, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs (including those prescribed) which may adversely alter my behavior or judgement.

Printed name of Medical Professional Applicant: ______________________________

Signature of Medical Professional Applicant: ______________________________

Health care provider's summary and elaboration of all pertinent data. Please comment on all positive answers.

Health Care Provider: ______________________________ Date: __________

Documentation of Physical Examination

Name: ______________________________ Date of Exam: ____________

BP: ______ / ______ Temp: ________ Pulse: ________ Respiration: ________ Weight: ________ Height: ________

Examination: (Must be within 6 months of application)

	Normal	Abnormal	NE	Notes: Describe abnormality with pertinent numeral before comment.
1. General Appearance	☐	☐	☐	
2. Skin	☐	☐	☐	
3. Head	☐	☐	☐	
4. Eyes	☐	☐	☐	
5. Ophthalmoscopic	☐	☐	☐	
6. Ears	☐	☐	☐	
7. Nose	☐	☐	☐	
8. Mouth/throat	☐	☐	☐	
9. Neck/thyroid	☐	☐	☐	
10. Lymphatics	☐	☐	☐	
11. Breasts	☐	☐	☐	
12. Thorax/lungs	☐	☐	☐	
13. Heart	☐	☐	☐	
14. Abdomen	☐	☐	☐	
15. Vascular system	☐	☐	☐	
16. Extremities/feet	☐	☐	☐	
17. Spine	☐	☐	☐	
18. Musculoskeletal	☐	☐	☐	
19. Neurologic	☐	☐	☐	
20. Psychiatric	☐	☐	☐	

Diagnosis and assessment of medical problems:

☐ No Medical Problems

☐ Ongoing medical problems: (Explain)

Limitations/Recommendations: (Further specialist examinations, labwork, x-ray, immunizations, etc.)

☐ No Limitations

☐ Limitations: (Explain)

After examination as required and to the best of my knowledge, I have determined that this individual is free from any health impairment that is of potential risk to patients or which might interfere with the performance of his/her duties. This included the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances, which may alter the individual's behavior or judgement.

Printed Name of Physician/Health Care Provider: ______________________ Date: ____________

Physician/Health Care Provider Signature: ______________________

Physician/Health Care Provider Address: ______________________

______________________ Telephone: (   ) ____________