UPSTATE
UNIVERSITY HOSPITAL

EMPLOYEE/STUDENT HEALTH
Jacobsen Hall
750 East Adams Street
Syracuse, NY 13210
315-464-4260 (telephone)
315-464-5471 *(fax)*
Email: ESHealth@Upstate.edu

TO: Medical Staff Applicants

FROM: Jarrod Bagatell, MD
Director, Employee/Student Health

RE: Requirements for Medical Clearance to be credentialed

The New York State Department of Health requires: a complete medical history and physical exam, proof of immunity for rubella and rubeola, and surveillance for tuberculosis be submitted prior to granting medical staff privileges. In addition, evidence of immunity to varicella and hepatitis-B are required by Upstate policy and documentation of influenza vaccine for the current influenza season is mandated by the Hospital Executive Committee to medical staff to maintain privileges.

Requirements for Medical Clearance:

- ☐ Medical History and Physical exam within 6 months prior to beginning assignment
- ☐ Rubella Antibody Titer – ***(copy of actual lab report is required)***
- ☐ Rubeola Antibody Titer (if born on 1/1/1957 or later) — ***(copy of actual lab report is required)***
- ☐ Varicella — evidence of immunity by one of the following:
  - Varicella Antibody Titer — ***(copy of actual lab report is required)***
  - Documentation of two (2) varicella vaccines at least 4 weeks apart
- ☐ Hepatitis-B Surface Antibody Titer— ***(copy of actual lab report is required)***
- ☐ Influenza vaccination date for current flu season ***(documentation required)***
- ☐ Tuberculin Skin Test (PPD) — within **6** months prior to beginning assignment (prior BCG does not negate placing a PPD). IGRA (blood test) for tuberculosis is also acceptable and must be within **6** months prior to starting.
- ☐ Chest x-ray — is required if a prior tuberculin skin test has been **positive**, the x-ray must be done within **6** months prior to beginning assignment. A copy of the official x-ray report is required. You must also submit detailed documentation of the past positive PPD.

Your medical forms are reviewed only by the medical personnel of the Employee/Student Health Office. Please submit all required documents at one time by e-mail: ESHealth@upstate.edu or fax to: (315) 464-5471 or mail:

Employee/Student Health Office
Upstate Medical University
750 East Adams Street
Jacobsen Hall — 4th Floor
Syracuse, NY 13210

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

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	☐	☐
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**.

	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	☐	☐

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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: (   ) __________