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 mumps, varicella and hepatitis-B are required by Upstate policy.

Requirements for Medical Clearance:

- ☐ Medical History and Physical exam within **6** months **prior** to anticipated start date
- ☐ Rubella — if born on 1/1/1957 or later, evidence of immunity by **ONE** of the following:
  - Rubella IGG Antibody Titer — (***copy of actual lab report is required***)
  - Documentation of one (**1**) MMR vaccine on or after 1st birthday
- ☐ Rubeola — if born on 1/1/1957 or later, evidence of immunity by **ONE** of the following:
  - Rubeola IGG Antibody Titer — (***copy of actual lab report is required***)
  - Documentation of two (**2**) MMR vaccines, one on or after 1st birthday and at least 4 weeks apart
- ☐ Mumps — if born on 1/1/1957 or later, evidence of immunity by **ONE** of the following:
  - Mumps IGG Antibody Titer — (***copy of actual lab report is required***)
  - Documentation of two (**2**) MMR vaccines, one on or after 1st birthday and at least 4 weeks apart
- ☐ Varicella — evidence of immunity by **ONE** of the following:
  - Varicella IGG Antibody Titer — (***copy of actual lab report is required***)
  - Documentation of two (**2**) varicella vaccines, one on or after 1st birthday and at least 4 weeks apart
- ☐ Hepatitis-B Surface Antibody Titer—is **mandatory** (***copy of actual lab report is required***)
  - Documentation of three (3) Hepatitis-B vaccines is also required
- ☐ Tuberculosis — Documentation of negative Tuberculin Skin Test (TST) within 12 months prior to beginning assignment is required. IGRA (T-spot or QuantiFERON) is also acceptable and must be within **12** months prior to starting. An IGRA is preferred with history of prior BCG vaccination and must be done within **12** months prior to start date.

- ☐ Chest x-ray — If a prior TST has been positive, documentation of chest x-ray must be provided; a copy of the official x-ray report is required. You must also submit detailed documentation of the past positive TST and any treatment you may have received for latent tuberculosis. If the x-ray report is unable to be provided, an updated chest x-ray is needed and should be performed within **12** months of start date (formal report required).

The following vaccines are strongly encouraged, but not mandatory:

- ☐ COVID-19 vaccine(s) (***supporting documentation, including manufacturer and dates required***)
- ☐ Influenza vaccination date for current flu season (***supporting documentation required***)
- ☐ Tdap (***supporting documentation required***)

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. Documents may also be mailed to address at the top of our letterhead.

UPSTATE
UNIVERSITY HOSPITAL

MEDICAL HEALTH HISTORY FORM

EMPLOYEE/STUDENT HEALTH

Jacobsen Hall • 750 East Adams Street • Syracuse, NY 13210
315-464-4260 (telephone) • 315-464-5471 (fax) • *www.upstate.edu*

Last Name _____ First _____ MI _____ Date of Birth _____ Country of Birth _____

Local Address (No. and Street) _____ City _____ State _____ Zip _____ Telephone Number _____

Upstate Job Title _____ Department or Unit _____ Start Date _____ Emergency Contact _____ Telephone Number _____

★ *The information contained in this document is confidential. Subject to your responses, Upstate Employee/Student Health may require additional information from your treating provider.* ★

Personal medical provider: _____

Medications *(prescription, over the counter)*: _____

Medication allergies: _____

Latex allergies: _____

Seasonal/environmental allergies: _____

Hospitalizations in the last 10 years (List): _____

Surgeries in the last 10 years (List): _____

Miscellaneous:

Do you use tobacco? (smoke, vape, or chew) ☐ Yes / ☐ No

If yes, how much? _____

Do you use alcohol? ☐ Yes / ☐ No

If yes, how much/often? _____

Do you use any other recreational or illegal drugs? ☐ Yes / ☐ No

If yes, what substances? _____

Have you ever been treated or are currently being treated for drug or alcohol dependency? ☐ Yes / ☐ No

If yes, when? _____

Do you have visual or hearing limitations (glasses/contacts/color blindness/hearing loss or aids)? ☐ Yes / ☐ No

If yes, describe: _____

Do you have any physical or mental impairments or limitations? ☐ Yes / ☐ No

If yes, describe: _____

Have you ever received or do you currently need an accommodation in order to perform your work? ☐ Yes / ☐ No

If yes, describe: _____

Have you ever received an IEP (Individualized Education Program) or accommodation in connection with your education? ☐ Yes / ☐ No

If yes, describe: _____

Have you ever had a work-related injury or illness? ☐ Yes / ☐ No

If yes, describe: _____

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Have you ever or are you currently receiving worker's compensation or disability benefits? ☐ Yes / ☐ No

Have you ever lost more than one week or changed your job because of an injury or illness (either work or non-work related)? ☐ Yes / ☐ No

If yes, describe: _____

Tuberculosis (TB) Screening:

Have you ever had a positive TB test? ☐ Yes / ☐ No

If yes, were you treated for TB? ☐ Yes / ☐ No

In the last 12 months, have you lived outside the United States for longer than 1 month? ☐ Yes / ☐ No

Have you been in close contact with anyone with active TB? ☐ Yes / ☐ No

Do you take any medication(s) or have any health condition that suppresses your immunity? ☐ Yes / ☐ No

Have you ever been or are you currently being treated for an autoimmune disease or cancer? ☐ Yes / ☐ No

If yes, describe: _____

Please indicate below if you have ever had or currently have any of the following health conditions.

Skin/Endocrine:

Skin problems or chronic rash? ☐ Yes / ☐ No

Thyroid disease? ☐ Yes / ☐ No

Diabetes? ☐ Yes / ☐ No

Cardiac:

Chest pain/heart condition or attack? ☐ Yes / ☐ No

Palpitations/irregular heart beat? ☐ Yes / ☐ No

High blood pressure? ☐ Yes / ☐ No

Edema (swelling of legs/feet)? ☐ Yes / ☐ No

DVT/PE (Deep Vein Thrombosis/ Pulmonary Embolism)? ☐ Yes / ☐ No

Respiratory:

Asthma? ☐ Yes / ☐ No

COPD/Emphysema? ☐ Yes / ☐ No

Asbestosis/Sarcoidosis? ☐ Yes / ☐ No

Coughing up blood? ☐ Yes / ☐ No

Neurological:

Stroke or paralysis? ☐ Yes / ☐ No

Brain trauma (traumatic brain injury, Concussion)? ☐ Yes / ☐ No

Numbness/tingling of arms, hands, legs or feet? ☐ Yes / ☐ No

Weakness of the arms, hands, legs or feet? ☐ Yes / ☐ No

Chronic headaches or migraines? ☐ Yes / ☐ No

If yes how often? _____

Are you able to work during headache? ☐ Yes / ☐ No

Dizziness or fainting? ☐ Yes / ☐ No

Difficulties with balance, coordination, speech, memory or use of limbs? ☐ Yes / ☐ No

Seizure disorder? ☐ Yes / ☐ No

If yes, when was the last seizure? _____

What kinds of seizures do you have?

_____

Gastrointestinal and Kidney:

Stomach or intestinal problems? ☐ Yes / ☐ No

Liver disease/hepatitis? ☐ Yes / ☐ No

Kidney disease? ☐ Yes / ☐ No

Hernia? ☐ Yes / ☐ No

Musculoskeletal:

Joint pain, swelling, or injury? ☐ Yes / ☐ No

If yes, do you have difficulty walking, lifting, bending or squatting? ☐ Yes / ☐ No

Arthritis? ☐ Yes / ☐ No

Back pain or injury? ☐ Yes / ☐ No

Neck pain or injury? ☐ Yes / ☐ No

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Orthopedic conditions requiring surgery?.....☐ Yes / ☐ No

If yes, when/what type of surgery?

_____

Do you have difficulty assuming normal body positions? .....☐ Yes / ☐ No

Are you currently working with any restrictions?.....☐ Yes / ☐ No

If yes, describe: _____

_____

Mental Health:

Depression/Anxiety? .....☐ Yes / ☐ No

Bipolar disorder? .....☐ Yes / ☐ No

ADD/ADHD (Attention Deficit Disorder)?.....☐ Yes / ☐ No

PTSD (Post-traumatic Stress Disorder)?.....☐ Yes / ☐ No

Schizophrenia? .....☐ Yes / ☐ No

Difficulties with concentration, processing information, timed tasks, interpersonal relationships, or stress?.....☐ Yes / ☐ No

Any other mental health condition?.....☐ Yes / ☐ No

If yes, describe: _____

_____

Do you have any other medical conditions not listed above? Please provide any additional information or detail in the space below:

Is there any reason you cannot fully perform all duties that your assigned employment or volunteer work will require on any shift?.....☐ Yes / ☐ No

If yes, describe restriction: _____

I understand that any offer of employment or granting of medical staff privileges is contingent upon my ability to perform, with or without a reasonable accommodation, the essential duties for my position based on medical examination and any other information necessary to determine medical clearance for my position. Such examination is consistent with business necessity and requires that determination be made that I do not pose a risk to myself, patients, co-workers, or other individuals in the workplace. I certify that the information documented on this form is true and complete to the best of my knowledge. I understand that misrepresentation or omission of facts may delay/prevent my employment or grant of membership/privileges on the medical staff, or may be cause for my subsequent termination.

Printed name: _____ Signature: _____ Date: _____

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Examining healthcare provider: _____

Additional comments by examining healthcare provider: _____

_____

_____

Clinician signature: _____ Date: _____

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UPSTATE
MEDICAL UNIVERSITY

Report of Medical Examination

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

Name: _____ Date of Exam: _____

Dept./Program: _____

Clinical Evaluation: Check each item in the appropriate column; "NE" is not evaluated

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

Height: _____ Weight: _____

Temperature: _____ Blood Pressure: Systolic: _____ Diastolic: _____ Pulse: _____

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)

(continue on back if necessary)

Health Care Provider *(print)*: _____ STATE AND LICENSE #

Health Care Provider *(signature)*: _____

Address: _____

_____ Telephone No.: ( ) _____