Downtown Campus
Employee/Student Health Office
175 Elizabeth Blackwell St.
Syracuse, NY 13210
315-464-4260 (telephone)
315-464-5471 (fax)
eshealth@upstate.edu

UPSTATE
MEDICAL UNIVERSITY

Community Campus
Employee Health Office
4900 Broad Road
Syracuse, NY 13215
315-492-5624 (telephone)
315-492-5117 (fax)
eshealth@upstate.edu

Non-**E**mployee **M**edical **C**learance
(Certificate of Health Statement)
Please Print Legibly

Name: (last)_____(first)_____ DOB: _____ Today's Date: _____
Phone Number: _____ Email: _____
Upstate Job Title or Activity: _____ Begins: _____ Ends: _____
Your school/agency: _____ Is patient contact expected? Yes / No *(circle one)*
Upstate Contact and Phone #: _____
Flu vaccination date (current season, Aug-May): _____ (Must include copy of vaccination record)

(CONFIDENTIAL)

Section I: In the past year have you had or currently have: *(explain all YES responses, add pages as needed)*

1. Any medical illness or surgery? No / Yes _____
2. Contagious illness? No / Yes _____
3. Mental health condition? No / Yes _____
4. Frequent use of alcohol or any use of illicit drugs? No / Yes _____
5. Skin infection or open (non-healing) wounds? No / Yes _____
6. Recent weight loss, cough, fever, loss of appetite and/or night sweats? No / Yes _____
7. Medications? *(list)* _____ Allergies? _____
8. Disability/Limitations? _____
9. Lived or travelled outside of the U.S. for more than 1 month? No / Yes _____
10. Close contact with someone who has had active tuberculosis (TB)? No / Yes _____
11. Medical condition(s) or take medication(s) that might weaken your immune system? No / Yes _____

I certify that the above information is true and complete: _____(signature) Date: _____

Section II:

MUST INCLUDE VACCINE RECORDS OR LAB REPORTS

1. Documentation of immunity to the below:
   a. ___ Rubeola (Measles): **2** doses of MMR vaccine **or** positive Rubeola antibody titer
   b. ___ Mumps: **2** doses of MMR vaccine **or** positive Mumps antibody titer
   c. ___ Rubella (German measles): **1** dose of MMR vaccine **or** positive Rubella antibody titer
   d. ___ Varicella (Chicken pox): **2** doses of Varicella vaccine **or** positive Varicella antibody titer
2. Tuberculosis testing *(must be within 12 mo. of start date)*:(***if positive, Chest X-ray report is required****)*
   ___ Tuberculin Skin Test (TST)
   Date placed: _____ Date read: _____
   Reaction (induration measured in mm): ____ mm
   or ___TB blood test (such as Quantiferon or T-Spot) Date: _____ Result: _____
   (*__) Chest X-ray report date: _____
3. Physical examination date (within 12 months of anticipated start date): _____

Required if exam outside of Employee/Student Health: ***(TO BE COMPLETED BY HEALTH CARE PROVIDER)***

The person listed above underwent a physical examination on _____ (date) and was found to be free of communicable disease and is able to work without restrictions or limitations.

Provider Name (print): _____ Signature: _____ Date: _____
Provider medical license number/state: _____ Phone: _____
Provider's Stamp/Address: **ESH USE**

Reviewed 8/2019