

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 and documentation of influenza vaccine for the current influenza season is mandated by the Hospital Executive Committee for medical staff to maintain privileges.

Requirements for Medical Clearance:

- Medical History and Physical exam within **6** months prior to anticipated start date
- Rubella IGG Antibody Titer — evidence of immunity by **ONE** of the following:
 - o Rubella IGG Antibody Titer — **(copy of actual lab report is required)**
 - o Documentation of one (1) MMR vaccine on or after 1st birthday
- Rubeola IGG Antibody Titer — if born on 1/1/1957 or later, evidence of immunity by **ONE** of the following:
 - o Rubeola IGG Antibody Titer — **(copy of actual lab report is required)**
 - o Documentation of two (2) MMR vaccines, one on or after 1st birthday and at least 4 weeks apart
- Mumps IGG Antibody Titer — if born on 1/1/1957 or later, evidence of immunity by **ONE** of the following:
 - o Mumps IGG Antibody Titer — **(copy of actual lab report is required)**
 - o 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:
 - o Varicella IGG Antibody Titer — **(copy of actual lab report is required)**
 - o 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)**
 - o Documentation of three (3) Hepatitis-B vaccines is also required
- Influenza vaccination date for current flu season **(documentation required)**
- Tuberculin Skin Test (PPD) — within **6** months prior to beginning assignment (prior BCG vaccination 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 **12** 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 to the address listed above.

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Ophthalmoscopic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Mouth/throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Neck/thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Lymphatics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Thorax/lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Vascular system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Extremities/feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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: () _____



Employee/Student Health

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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 explanation.

	No	Yes		No	Yes
1. Chicken pox or shingles.....	<input type="checkbox"/>	<input type="checkbox"/>	25. Broken bones	<input type="checkbox"/>	<input type="checkbox"/>
2. Measles	<input type="checkbox"/>	<input type="checkbox"/>	26. Bone or joint problems.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Mumps	<input type="checkbox"/>	<input type="checkbox"/>	27. Arthritis/gout	<input type="checkbox"/>	<input type="checkbox"/>
4. Skin problems or chronic rash.....	<input type="checkbox"/>	<input type="checkbox"/>	28. Back pain/injury	<input type="checkbox"/>	<input type="checkbox"/>
5. Eye problems.....	<input type="checkbox"/>	<input type="checkbox"/>	29. Numbness/tingling legs or feet	<input type="checkbox"/>	<input type="checkbox"/>
6. Hearing loss or ear problems	<input type="checkbox"/>	<input type="checkbox"/>	30. Knee pain/injury	<input type="checkbox"/>	<input type="checkbox"/>
7. Chronic cough.....	<input type="checkbox"/>	<input type="checkbox"/>	31. Foot pain/injury	<input type="checkbox"/>	<input type="checkbox"/>
8. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	32. Neck pain/injury	<input type="checkbox"/>	<input type="checkbox"/>
9. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	33. Loss of limb	<input type="checkbox"/>	<input type="checkbox"/>
10. Lung problems.....	<input type="checkbox"/>	<input type="checkbox"/>	34. Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
11. Tuberculosis or positive TB skin test.....	<input type="checkbox"/>	<input type="checkbox"/>	35. Dizziness or fainting	<input type="checkbox"/>	<input type="checkbox"/>
12. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	36. Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>
13. Heart trouble/attack.....	<input type="checkbox"/>	<input type="checkbox"/>	37. Severe weakness or tiredness.....	<input type="checkbox"/>	<input type="checkbox"/>
14. Palpitations/irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	38. Depression or anxiety	<input type="checkbox"/>	<input type="checkbox"/>
15. Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	39. Emotional or psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>
16. High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	40. Drug or Alcohol dependency	<input type="checkbox"/>	<input type="checkbox"/>
17. Stroke or paralysis	<input type="checkbox"/>	<input type="checkbox"/>	41. Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>
18. Stomach or intestinal problem	<input type="checkbox"/>	<input type="checkbox"/>	42. Bleeding or blood disorder	<input type="checkbox"/>	<input type="checkbox"/>
19. Liver disease/hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>	43. Immune suppression	<input type="checkbox"/>	<input type="checkbox"/>
20. Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	44. Chronic/recurrent infection	<input type="checkbox"/>	<input type="checkbox"/>
21. Weight change	<input type="checkbox"/>	<input type="checkbox"/>	45. Tumor/cancer	<input type="checkbox"/>	<input type="checkbox"/>
22. Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	46. Anemia	<input type="checkbox"/>	<input type="checkbox"/>
23. Shoulder/elbow/wrist/hand pain	<input type="checkbox"/>	<input type="checkbox"/>	47. Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
24. Numbness/tingling of arms or hands	<input type="checkbox"/>	<input type="checkbox"/>	48. Any other illness not listed	<input type="checkbox"/>	<input type="checkbox"/>

NAME: _____

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

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

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: _____